Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
-	62	ST		**Transaction Set Header**	R	R			-	
			01	Transaction Set ID Code	R	R			"837"	Auto Plug: "837"
			02	Transaction Set Control Number	R	R		Unique number associated with transaction set. Must equal control number in SE02.		Assigned by Sender
-	63	BHT		**Beginning of Hierarchical Transaction**	R	R			-	
			01	Hierarchical Structure Code	R	R		Code indicating the hierarchical application structure of a transaction set. Use "0019" to denote Information Source, Subscriber, Dependent.	"0019"	Auto plug: "0019"
			02	Transaction Set Purpose Code	R	R		Conveys the electronic transmission status of the 837 batch, either "original" ('00') or "reissue ('18').	Derive: '00' or '18'	Assign "00" or "18" depending on Batch Status
			03	Reference ID (Origination Application Transaction ID) - **operates as a batch control number**	R	R		Number assigned by the orginator to identify the transaction within the originator's business application system.	derive	Assigned by Sender
			04	Transaction Set Creation Date	R	R		Date that the transaction was created within the business application system. CCYYMMDD format.	derive	Assigned by Sender
			05	Transaction Set Creation Time	R	R		Time that the transaction was created within the business application system In HHMM or HHMMSS or HHMMSSD or HHMMSSDD format.	derive	Assigned by Sender
			06	Transaction Type Code (Claim or Encounter ID)	R	R		Indicates contents of batch: 'CH' for claims, 'RP' for encounters, 'CH' for claims and encounters, other as agreed upon by trading partners.	"RP"	Auto plug; "RP"
-	66	REF		**Transmission Type Identification**	R	R			-	
			01	Reference ID qualifier	R	R		Use "87" for functional category.	"87"	Auto plug: "87"
			02	Reference ID (Transmission Type Code)	R	R		Use: "004010X098DA1" for test, "004010X098A1" for production.	derive: "004010X098DA1" or "004010X098A1"	Sender assigns "004010X098DA1" for Test/Pilot or "004010X098A1" for Production
1000A		**Submitter Name**			R	R			-	
1000A	67	NM1		Submitter Name	R	R		Recommended to use the transaction submitter, page 40 of TIG.		
			01	Entity ID Code	R	R		Code denoting submitter as entity.	"41"	Augo plug: "41"
			02	Entity Type Qualifier	R	R		Derive: "1" for Person, "2" for Non-person entity.	"2"	Augo plug: "2"
			03	Last Name or Organization Name (Submitter Name)	R	R		Last name of individual or organization name.	hardcode with MCO's name	MCO's name
			04	Submitter First Name	s	n		First Name of Submitter	-	Not required
			05	Submitter Middle Name or Middle Initial	s	n		Middle Name or Middle Initial of Submitter	-	Not required
			08	ID Code Qualifier	R	R		Code designating the type of ID Number	"46"	
			09	Submitter Primary ID Number (Health Plan tape supplier number)	R	R		Submitter Primary ID Number **? What goes here ? Tax id or AHCCCS ID?**	*? What goes here ?*	6 Digits of HP ID + 3 digits of TSN
1000A	71	PER		Submitter EDI Contact Info	R	R		Contact information refers to person in the submitting organization who deals with transmission issues.		

Addenda has been incorporated
Last Updated: 02/11/2003
Web Posting: Version 1.0

n = not needed s = situational R = Required

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			01	Contact Function Code	R	R		Code identifying responsibility of the person named as an "Information Contact" ("IC").	"IC"	Auto plug: "IC"
			02	Submitter Contact Name	R	R		Name of the person to contact.	hardcode with MCO's info	MCO's Contact Name
			03	Communication Number Qualifier	R	R		Code identifying the type of communication number: "ED" is the Electronic Data Interchange Access Number, "EM" for Electronic Mail, "FX" for Fax, "TE" for Telephone.	hardcode with MCO's info	Select appropriate HIPAA value
			04	Communication Number	R	R		Complete telephone number including country or area code.	hardcode with MCO's info	Number that goes with value selected
			05	Communication Number Qualifier	s	s		Code identifying the type of communication number: "ED" is the Electronic Data Interchange Access Number, "EM" for Electronic Mail, "FX" for Fax, "TE" for Telephone.	if available, hardcode with MCO's info	AHCCCS does not need the secondary contact information
			06	Communication Number	s	s		Complete telephone number including country or area code.	if available, hardcode with MCO's info	AHCCCS does not need the secondary contact information
			07	Communication Number Qualifier	s	s		Code identifying the type of communication number: "ED" is the Electronic Data Interchange Access Number, "EM" for Electronic Mail, "FX" for Fax, "TE" for Telephone.	if available, hardcode with MCO's info	AHCCCS does not need the secondary contact information
			08	Communication Number	s	s		Complete telephone number including country or area code.	if available, hardcode with MCO's info	AHCCCS does not need the secondary contact information
1000B		**Receiver Name**			R	R			-	
1000B	**74**	**NM1**		Receiver Name	R	R				
			01	Entity ID Code	R	R		Identify whether an entity or person is receiving transmission.	"40"	Auto plug: "40"
			02	Entity Type Qualifier	R	R		Code qualifying the type of entity, "2" is a non-person entity.	"2"	Auto plug: "2"
			03	Last Name or Organization Name (Receiver Name)	R	R		Identify entity or person receiving transmission.	"AHCCCS"	Auto plug: "AHCCCS"
			08	Identification Code Qualifier	R	R		Code designating the system/method of code structure used for ID Code. Use "46" for Electronic Transmitter ID Number (ETIN).	"46"	Auto plug: "46"
			09	ID Code (Receiver Primary ID)	R	R		Receiver Primary ID Number.	harcode	Auto plug: 86-6004791
2000A		**Billing/Pay-to Provider Hierarchical Le**			R	R			-	
2000A	**77**	**HL**		Billing/Pay-to Provider Hierarchical Level	R	R			-	
			01	Hierarchical ID Number	R	R		Unique number assigned by the sender to identify a particular data segment in a hierachical structure. HL-01 must begin with "1" and be incremented by one each time an HL is used in the transactions. Only numeric values are allowed in HL-01.	calculate - maintain a counter (tally) field	Assigned by Sender
			03	Hierarchical Level Code	R	R		Code defining the characteristic of a level in a hierarchical structure. Use "20" for information source.	"20"	Auto plug: "20"
			04	Hierarchical Child Code	R	R		Code indicating if there are hierarchical child data segments surordinate to the level being described. Use "1" for Additional Subordinate HL Data Segment.	"1"	Auto plug: "1"

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
2000A	79	PRV		Billing/Pay-to Provider Specialty Info	s	s	ignore	Required if rendering provider is the billing provider. This PRV is not used when the Billing or Pay-to provider is a group and the individual rendering provider is in loop 2310B.		This information is not required because AHCCCS does not use it to price or "value" encounters. This is a clarification from the Addenda
			01	Provider Code	R	R	ignore	Code identifying the type of provider: "BI" for Billing, "PT" for Pay-To.	derive	Not Needed
			02	Reference ID Qualifier	R	R	ignore	Code qualifying the Reference ID. Use "ZZ" for Mutually Defined Health Care Provider Taxonomy code list.	"ZZ"	Not Needed
			03	Reference ID (Provider Taxonomy Code / Provider Specialty Code)	R	R	ignore	Provider's specialty.	either dummy value or real value	Not Needed
2000A	81	CUR		Foreign Currency Info	s	n	n	PHS does not pay claims for services rendered outside of the U.S.A.	-	
2010AA		**Billing Provider Name**			R	R			-	For AHCCCS the Billing Provider and the Pay-to Provider are the same entity. Billing/Pay-to Provider may be the Rendering Provider in some cases or may be a separate entity receiving payment on behalf of the Rendering Provider
2010AA	84	NM1		Billing Provider Name **(Billing Entity)**	R	R		Actually the billing entity (which may or may not be the health care provider [rendering provider]).		
			01	Entity ID Code	R	R		Code identifying an entity type. Use "85" for Billing Provider.	"85"	Auto plug: "85"
			02	Entity Type Qualifier	R	R		Code qualifying the type of entity: "1" is a person, "2" is a non-person entity.	derive	Select appropriate HIPAA value
			03	Last Name or Organization Name of Billing Provider (Billing Entity)	R	R		Billing Provider Name	box 31 (if also the rendering provider) - not true if there is a separate billing entity	Select from Box # 33 if Billing Provider is different from Rendering Provider. Select from box # 31 if Rendering Provider is also the Billing Provider
			04	First Name of Billing Provider (Billing Entity)	s	s		First Name of Billing Provider	box 31 (if also the rendering provider) - not true if there is a separate billing entity	This element is not required unless NM102 = 1 (person).
			05	Middle Name of Billing Provider	s	s		Middle Name or Middle Initial of Billing Provider	box 31 (if also the rendering provider) - not true if there is a separate billing entity	This element is not required unless NM102 = 1 (person).
			07	Name Suffix of Billing Provider	s	s		Billing Provider Name Suffix	box 31 (if also the rendering provider) - not true if there is a separate billing entity	This element is not required unless NM102 = 1 (person) and the suffix is known.
			08	ID Code Qualifier for Billing Provider	R	R		Code designating the system/method of code structure used for ID Code: "24" for Employer ID Number, "34" for Social Security Number, "XX" for HCFA National Provider Number.	derive - either "24" or "34"	Select appropriate HIPAA value

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			09	ID Code of Billing Provider	R	R		Billing Provider Primary ID Number **? Use the Tax ID or SSN ?**	box 25 (if also the rendering provider) - not true if there is a separate billing entity	Submit EIN or SSN of Billing Provider. Can use box # 25 if Rendering Provider is also the Billing Provider. Otherwise, Box # 33 can be used.
2010AA	88	N3		Billing Provider Address	R	R				
			01	Billing Provider Address Line 1	R	R		Billing Provider Address Line 1	box 31 (if also the rendering provider) - not true if there is a separate billing entity	Submit Billing Provider Address if Rendering Provider is the Billing Provider. Otherwise, box # 33 can be used.
			02	Billing Provider Address Line 2	s	S		Billing Provider Address Line 2	box 31 (if also the rendering provider) - not true if there is a separate billing entity	Only use this element if additional address information is needed.
2010AA	89	N4		Billing Provider City/State/Zip	R	R				
			01	Billing Provider City Name	R	R		Billing Provider City Name	box 31 (if also the rendering provider) - not true if there is a separate billing entity	Submit Billing Provider City if Rendering Provider is the Billing Provider. Otherwise, box # 33 can be used for City.
			02	Billing Provider's State	R	R		Billing Provider's State	box 31 (if also the rendering provider)	Submit Billing Provider State if Rendering Provider is the Billing Provider. Otherwise, box # 33 can be used for State.
			03	Billing Provider's Zip Code	R	R		Billing Provider's Zip Code	box 31 (if also the rendering provider) - not true if there is a separate billing entity	Submit Billing Provider Zip Code if Rendering Provider is the Billing Provider. Otherwise, box # 33 can be used for Zip Code.
			04	Billing Provider's Country Code	s	s		Billing Provider's Country Code	box 33 (? if it is the billing prov) if needed	Not Needed by AHCCCS
2010AA	91	REF		Billing Provider Secondary ID	s	R	R	Required if secondary ID is needed for identification of the billing entity.		
			01	Reference ID Qualifier	R	R		See chart of codes on page 92 of TIG. Use "1D" for Medicaid Provider Number.	"1D"	Auto plug: "1D"
			02	Reference ID	R	R		Billing Provider Secondary ID Number. **Note: Brent will verify service location usage with Provider Registration.**	AHCCCS ID + two digit service location code	Registerd Provider AHCCCS ID + two digit service location code
2010AA	94	REF		Credit/Debit Card Billing Info	s	n	n	data never sent to payer - only for use between the provider and a collection service	-	This information should not be sent.
2010AA	96	PER		Billing Provider Contact Info (for Billing Entity)	s	s		**Required if the billing entity is not the submitter (in 1000A PER segment).**		AHCCCS does not need the Billing Provider Contact Information. All contacts will be with the MCO.
			01	Contact Function Code	R	R		Use "IC" for Information Contact.	"IC"	Not Needed

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			02	Billing Provider Contact Name	R	R			not on HCFA-1500	Not Needed
			03	Communication Number Qualifer	R	R		Code identifying type of communication number: "EM" for e-mail, "FX" for fax, "TE" for telephone, "EX" for phone extension.	not on HCFA-1500	Not Needed
			04	Communication Number	R	R		Contact phone number for Billing Provider.	not on HCFA-1500	Not Needed
			05	Communication Number Qualifer	s	s		Code identifying type of communication number: "EM" for e-mail, "FX" for fax, "TE" for telephone, "EX" for phone extension.	not on HCFA-1500	Not Needed
			06	Communication Number	s	s		Contact phone number for Billing Provider.	not on HCFA-1500	Not Needed
			07	Communication Number Qualifer	s	s		Code identifying type of communication number: "EM" for e-mail, "FX" for fax, "TE" for telephone, "EX" for phone extension.	not on HCFA-1500	Not Needed
			08	Communication Number	s	s		Contact phone number for Billing Provider.	not on HCFA-1500	Not Needed
2010AB		**Pay-to Provider Name**			s	s		**Required if Pay-to provider is not the billing provider (billing entity)**	-	Since in the AHCCCS Provider environment the Billing Provider and the Pay-to Provider are the same entity, the loop is not neded. The HIPAA IG only requires this loop if they are different.
2010AB	99	NM1		Pay-to Provider Name	R	R		Required if pay-to provider is not the billing provider.		
			01	Entity ID Code	R	R		Code identifying that entity is the Pay-To Provider, use "87".	"87"	Not Needed
			02	Entity Type Qualifer	R	R		Code qualifying the type of entity: "1" is a person, "2" is a non-person entity.	derive	Not Needed
			03	Pay-to Provider Last Name or Organizational Name	R	R		Pay-to provider last name or organization name	box 33	Not Needed
			04	Pay-to Provider First Name	R			Pay-to Provider First Name	box 33 if needed	Not Needed
			05	Pay-to Provider Middle Name or Middle Initial	s	s		Pay-to Provider Middle Name or Middle Initial	box 33 if needed	Not Needed
			07	Pay-to Provider Name Suffix	s	n		Pay-to Provider Name Suffix	box 33 if needed	Not Needed
			08	ID Code Qualifier for Pay-to Provider	R	R		Code designating the system/method of code structure used for ID Code: "24" for Employee ID Number, "34" for Social Security Number, "XX" for HCFA National Provider Number.	? AHCCCS number	Not Needed
			09	Pay-to Provider Primary ID Number	R	R		? Pay-to Provider's AHCCCS Number ?	? GRP# in box 33	Not Needed
2010AB	103	N3		Pay-to Provider Address	R	R			?	Not Needed
			01	Pay-to Provider Address Line 1	R	R		Pay-to Provider Address Line 1	box 33	Not Needed
			02	Pay-to Provider Address Line 2	s	s		Pay-to Provider Address Line 2	box 33 if needed	Not Needed

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
2010AB	104	N4		Pay-to Provider City/State/Zip	R	R				Not Needed
			01	Pay-to Provider City Name	R	R		Pay-to Provider City Name	box 33	Not Needed
			02	Pay-to Provider State Code	R	R		Pay-to Provider State Code	box 33	Not Needed
			03	Pay-to Provider Zip Code	R	R		Pay-to Provider Zip Code	box 33	Not Needed
			04	Pay-to Provider Country Code	s	n		Pay-to Provider Country Code	box 33 if needed	Not Needed
2010AB	106	REF		Pay-to Provider Secondary ID	s	s		Required if secondary ID is needed for identification of the pay-to provider.	?	Not Needed
			01	Reference ID Qualifier	R	R		Code qualifying the type of Reference ID: see chart on pages 106-107 of the TIG.	?	Not Needed
			02	Pay-to Provider Additional ID	R	R		Pay-to Provider Additional ID	?	Not Needed
2000B		Subscriber Hierarchical Level			R	R			-	
2000B	108	HL		Subscriber Hierarchical Level	R	R				
			01	Subscriber Hierarchical Level	R	R		Unique number assigned by the sender to identify a particular data segment in a hierachical structure. HL-01 must begin with "1" and be incremented by one each time an HL is used in the transactions. Only numeric values are allowed in HL-01.	create and increment a counter (tally)	Assigned by Sender
			02	Hierarchical ID Number	R	R		Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to.	use the counter from the parent HL segment	Assigned by Sender
			03	Hierarchical Level Code	R	R		Code defining the characteristic of a level in a hierarchical structure. Use "22" for subscriber.	"22"	Auto plug: "22"
			04	Hierarchical Child Code	R	R		Code indicating if there are hierarchical child data segments surordinate to the level being described. Use "0" for no subordinate HL Data Segment.	"0"	Auto plug: "0"
2000B	110	SBR		Subscriber Info	R	R		Medicare insurance type code is required when Medicare is the destination payer and Medicare is not the primary payer		
			01	Payer Responsibility Sequence Number Code	R	R		Code identifying the insurance carrier's level of responsibility for payment of the claim.	?	Select valid HIPAA value
			02	Relationship Code	s	s		Code indicating the relationship between two individuals. Use "18" as all patients are subscribers at PHS.	"18" (Box 6 should be "Self")	Auto plug: "18"
			03	Insured Group or Policy Number	s	s		Insured Group or Policy Number	? Box 11	Not needed by AHCCCS. This element is required if the subscriber's payer identification includes Group or Plan Number.
			04	Group or Plan Name	s	s		Group or Plan Name	box 11c	Not needed by AHCCCS. This element is required if the subscriber's payer identification includes Group or Plan Name.

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			05	Insurance type code	s	s		Required when the destination payer is Medicare and Medicare is not the primary payer (SBR-01 equal "S" or "T").	?	Not Needed by AHCCCS. This element is required when the destination payer (Loop 2010BB) is Medicare and Medicare is not the primary payer (SBR01 = "S" or "T")
			09	Claim Filing Indicator Code	s	s		Code identifying type of claim.	? "MC" for Medicaid - box 1?	Not Needed by AHCCCS. This element is not used after PlanID is mandated.
2000B	114	PAT		Patient Info	s	s		required if subscriber is the patient and if info is needed: date of death, newborn birth weight, patient's weight, pregnant		
			05	Date Time Perod Format Qualifier	s	s		Code indicating the date format. Required if the patient is deceased and the date of death is known.	"D8"	Auto plug: "D8"
			06	Date of Death of Patient/Subscriber	s	s		Date of Death in CCYYMMDD format. Required if the patient is deceased and the date of death is known.	?	This element is required if patient is known to be deceased and the date of death is available.
			07	Unit or Basis for Measurement Code	s	s		Code specifying the units in which a value is being expressed. Required when the patient's weight is needed.	"01"	Auto plug: "01" if PAT08 is used.
			08	Patient Weight	s	s		Required on (1) claims involving EPO (epoetin) for patients on dialysis and Medicare Durable Medical Equipment for Regional Carriers certificate of medical necessity (DMERC CMN).	?	This element can be sent if applicable.
			09	Pregnancy Indicator	s	s		Pregnancy Indicator - required when mandated law.	?	Auto plug: "Y" or "N" if applicable.
2010BA		**Subscriber Name**			R	R			-	
2010BA	117	NM1		Subscriber Name	R	R				
			01	Entity ID Code	R	R		Code identifying the entity as the subscriber, use "IL"	"IL"	Auto plug: "IL"
			02	Entity Type Qualifer	R	R		Code qualifying the type of entity: "1" is a person, "2" is a non-person entity.	"1"	Auto plug: "1"
			03	Subscriber's Last Name	R	R		Subscriber's Last Name	box 2	Recipient's Last Name
			04	Subscriber's First Name	s	s		Subscriber's First Name	box 2	Recipient's First Name. It is required since NM102 = 1 (person)
			05	Subscriber's Middle Name or Middle Initial	s	s		Subscriber's Middle Name or Middle Initial	box 2	Recipient's Middle Name or Initial if known.
			07	Subscriber Name Suffix	s	s		Subscriber Name Suffix	box 2	Not Needed
			08	ID Code Qualifier for Subscriber	s	s		Code designating the system/method of code structure used for ID Code: "MI" for Member ID Number, "ZZ" for Mutually Defined.	"MI"	Auto plug: "MI"
			09	Subscriber Primary ID	s	R	R	AHCCCS ID - required if the subscriber is the patient.	box 1a	Recipient's AHCCCS ID
2010BA	121	N3		Subscriber Address	s	R		Required if subscriber is the patient.		
			01	Subscriber Address Line 1	R	R		Subscriber Address Line 1	box 5	Use box # 5 for Recipient's Address
			02	Subscriber Address Line 2	s	s		Subscriber Address Line 2	box 5 if continuation is needed	Use box 5 if continuation is needed for Recipient's Address
2010BA	122	N4		Subscriber City/State/Zip	s	R		**required if subscriber is the patient**		
			01	Subscriber City Name	R	R		Subscriber City Name	box 5	Use box # 5 for Recipient's City
			02	Subscriber State Code	R	R		Subscriber State Code	box 5	Use box # 5 for Recipient's State

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			03	Subscriber Zip Code	R	R		Subscriber Zip Code	box 5	Use box # 5 for Recipient's Zip Code
			04	Subscriber Country Code	s	s		Subscriber Country Code	box 5	This element does not applied to AHCCCS
2010BA	124	DMG		Subscriber Demographic Info	s	R		**Required if subscriber is the patient.**	box 3	
			01	Date Time Perod Format Qualifier	R	R		Code indicating the date format.	"D8"	Auto plug: "D8"
			02	Patient Date of Birth	R	R		Patient Date of Birth	box 3	Use box #3 for Recipient's Date of Birth
			03	Gender Code	R	R		Gender Code	box 3	AHCCCS expects values: "F" or "M".
2010BA	126	REF		Subscriber Secondary ID Info	s	n		Required if secondary identification is needed. **Is this needed?**	?	This segment does not apply to AHCCCS
			01	Reference ID Qualifier	R	n		Code qualifying the Reference ID. Refer to table on pages 126 127 of TIG for.	?	Not needed
			02	Subscriber Supplemental ID	R	n		Subscriber Supplemental ID	?	Not needed
	128	REF		Property and Casualty Claim Info	s	n	n	**(?Required if there is a property or casualty claim.) Not required for HIPAA.**	?	This segment does not apply to AHCCCS
			01	Reference ID Qualifier	R	n	n	Code qualifying the Reference ID. Use "Y4" for Agency Claim Number.	"Y4"	Not needed
			02	Property Casualty Claim Number	R	n	n	Property Casualty Claim Number	?	Not needed
2010BB		**Payer Name**			R	R		This is the destination payer, AHCCCS.	-	AHCCCS is the destination payer
2010BB	130	NM1		Payer Name	R	R				
			01	Entity ID Code	R	R		Code identifying an entity. Use "PR" for payer.	"PR"	Auto plug: "PR"
			02	Entity Type Qualifer	R	R		Code ualifying the type of entity. Uuse "2" for non-person entity.	"2"	Auto plug: "2"
			03	Payer Name	R	R		Last name or organization name of payer.	"AHCCCS"	"AHCCCS"
			08	ID Code Qualifier for Payer	R	R		Code designating the system/method of code structure used for ID code. Refer to table on page 131 of TIG.	?	Auto plug: PI
			09	ID Code for Payer	R	R		Payer Primary ID	?	Auto plug: 86-6004791 for AHCCCS Payor ID
2010BB	134	N3		Payer Address	s	n	ignore	Required when the submitter intends for the claim to be printed on paper at the next EDI location.	?	
			01	Payer Address Line 1	R	n	ignore	Payer Address Line 1	PHS address	Not Required
			02	Payer Address Line 2	s	n	ignore	Payer Address Line 2	"	Not Required
2010BB	135	N4		Payer City/State/Zip	s	n	ignore	required when the submitter intends for the claim to be printed on paper at the next EDI location	?	
			01	Payer City Name	R	n	ignore	Payer City Name	PHS address	Not Required
			02	Payer State Code	R	n	ignore	Payer State Code	PHS address	Not Required
			03	Payer Zip Code	R	n	ignore	Payer Zip Code	PHS address	Not Required
			04	Country Code	s	n	ignore	Country Code		Not Required
2010BB	137	REF		Payer Secondary ID	s	n	ignore	Required if secondary ID is needed for adjudication of claim/encounter.		

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
2010BC		**Responsible Party Name**			**s**			Required for Medicare claims where there is a representative but the provider of medical services has neither the responsible party's signature nor the patient's signature on file.	**?**	**In general, the responsible party is someone who is not the subscriber/patient but who has financial responsibility for the bill. This whole loop does not apply to AHCCCS.**
2010BC	**139**	**NM1**		Responsible Party Name	**s**				**box 12**	**Not Needed**
			01	Entity ID Code	**R**			Code identifying an entity. Use "QD" for Responsible Party.	**"QD"**	**Not Needed**
			02	Entity Type Qualifer	**R**			Code qualifying the type of entity: "1" is a person, "2" is a non-person entity.	**?**	**Not Needed**
			03	Responsible Party Last Name or Organization Name	**R**			Resonsible Party Last Name or Organization Name	**? Box 12**	**Not Needed**
			04	Responsible Party First Name	**s**			First Name of Responsible Party	**? Box 12**	**Not Needed**
			05	Responsible Party Middle Name	**s**			Middle Name of Responsible Party	**? Box 12**	**Not Needed**
			07	Responsible Party Name Suffix	**s**			Suffix of Responsible Party's Name	**? Box 12**	**Not Needed**
2010BC	**143**	**N3**		Responsible Party Address	**R**				**?**	**Not Needed**
			01	Responsible Party Address Line 1	**R**			Responsible Party Address Line 1	**?**	**Not Needed**
			02	Responsible Party Address Line 2	**s**			Responsible Party Address Line 2	**?**	**Not Needed**
2010BC	**144**	**N4**		Responsible Party City/State/Zip	**R**				**?**	**Not Needed**
			01	Responsible Party City Name	**R**			Responsible Party City Name	**?**	**Not Needed**
			02	Responsible Party State Code	**R**			Responsible Party State Code	**?**	**Not Needed**
			03	Responsible Party Zip Code	**R**			Responsible Party Zip Code	**?**	**Not Needed**
			04	Responsible Party Country Code	**s**			Responsible Party Country Code	**?**	**Not Needed**
2010BD		**Credit/Debit Card Holder Name**			**s**	**n**	**n**	**this info is never sent to the payer :: neither PHS nor AHCCCS should receive this info. This info is strictly for use between a provider and a service organization..**	**-**	**This loop is only for use between a provider and a service organization offering patient collection services. It does not apply to AHCCCS**
2010BD	**146**	**NM1**		Credit/Debit Card Holder Name	**s**	**n**	**n**		**-**	**Not Needed**
2010BD	**150**	**REF**		Credit/Debit Card Info	**s**	**n**	**n**		**-**	**Not Needed**
2000C		**Patient Hierarchical Level**			**s**	**n**	**n**	**not required as patient is subscriber**	**-**	**This Loop is not needed when Patient and Subscriber are the same.**
2000C	**152**	**HL**		Patient Hierarchical Level	**s**	**n**	**n**		**-**	**Not Needed**
2000C	**154**	**PAT**		Patient Info	**R**	**n**	**n**		**-**	**Not Needed**

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
2010CA		**Patient Name**			**R**	**n**	**n**	**not required as patient is subscriber**	**-**	**Not Needed**
2010CA	**157**	**NM1**		Patient Name	**R**	**n**	**n**		**-**	**Not Needed**
2010CA	**161**	**N3**		Patient Address	**R**	**n**	**n**		**-**	**Not Needed**
2010CA	**162**	**N4**		Patient City/State/Zip	**R**	**n**	**n**		**-**	**Not Needed**
2010CA	**164**	**DMG**		Patient Demographic Info	**R**	**n**	**n**		**-**	**Not Needed**
2010CA	**166**	**REF**		Patient Secondary ID	**s**	**n**	**n**		**-**	**Not Needed**
2010CA	**168**	**REF**		Property and Casualty Claim Number	**s**	**n**	**n**		**-**	**Not Needed**
2300		**Claim Info**			**R**			Dates in Loop 2300 applies to all service lines unless overridden by a service line loop 2400. It is recommended that each transmission have no more than 5000 CLM segments.	**-**	
2300	**170**	**CLM**		Claim Info	**R**	**R**	**R**			
			01	Patient Account Number	**R**			Patient Account Number	**box 26**	**Expect Provider Patient Account Number**
			02	Total Claim Charge Amount	**R**			Total Submitted Charges	**box 28**	**Use Box 28 for Total Claim Charge Amount**
			05	Place of Service Code	**R**			Place of Service Code for the entire claim	**?**	
			05-1	Facility Code Type	**R**			Facility Code Type for the entire claim	**?**	**Select appropriate HIPAA value**
			05-3	Claim Frequency Code - **? Does this only apply to UB-92 claims ?**	**R**			Claim Frequency Code - **? Does this only apply to UB-92 claims ?**	**?**	**This element does not apply for Drug. Select appropriate HIPAA value.**
			06	Provider or Supplier Signature Indicator	**R**			Code indicating that the provider/supplier's signature is on file.	**?**	**Auto plug: "Y" if provider signature is on file. Otherwise, expect value "N".**
			07	Medicare Assignment Code	**R**			Medicare Assignment Code	**box 27**	**Select appropriate HIPAA value**
			08	Benefits Assignment Indicator	**R**			Benefits Assignment Indicator	**box 13**	**Auto plug: "Y" or "N" whichever applicable**
			09	Release of Information Code	**R**			Release of Information Code	**box 12**	**Select appropriate HIPAA value**
			10	Patient Signature Source Code	**s**			Code indicating how the patient authorization signature was obtained and how they are begin retained by the provider.	**?**	**This element is required except when CLM09 = "N". Select appropriate HIPAA value.**
			11	Accident / Employment / Related Causes	**s**			CLM11-1, CLM11-2 or CLM11-3 are required when the conditin begin reported is accident or employment related. If CLM11-1, CLM11-2 or CLM11-3 is "AP" (another party responsible), then map "Yes" to EA0-09.0. IF DTP - Date of Accident is used, the CLM11 is required.	**?**	
			11-1	Related Causes Code	**R**			Code identifying an accompanying cause of an illness, injury or accident: "AA" for auto accident, "AP" for another responsible party, "EM" for employment, "OA" for other accident.	**? box 10a, box 10b, box 10c**	**Send if applicable and appropriate HIPAA value is expected.**
			11-2	Related Causes Code	**s**			"	**"**	**Send if applicable and appropriate HIPAA value is expected.**
			11-3	Related Causes Code	**s**			"		**Send if applicable and appropriate HIPAA value is expected.**

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			11-4	Auto Accident State	s			Auto Accident State	box 10b State	This element is required if CLM11-1, 2, or 3 are sent. Use State Postal Code.
			11-5	Country Code	s			Country in which auto accident occurred	?	If send, select HIPAA valid values
			12	Special Program Code	s			Special Program Code. Refer to page 25 in the addenda for codes	?	Box 28
			16	Provider Participation Agreement	s			Provider Participation Agreement is required if a non-participating provider is submitting a participating claim. Send the "P" code indicates that a non-participating provider is sending a participating claim as allowed under certain plans.	?	The only value we know would be for EPSDT. Not Required
			20	Delay Reason Code	s			Delay Reason Code	?	Send if applicable and appropriate HIPAA value is expected.
deleted		DTP		Order Date - DELETED						
2300	182	DTP		Date - Initial Treatment Date	s			Required for spinal manipulation for Medicare Part B.	?	Send it if known
			01	Date Time Qualifier	R			Date Time Qualifier, use "454" for Order.	"454"	If send - Auto plug: "454"
			02	Date Time Period Format Qualifier	R			Code indicating format of time, use "D8" for CCYYMMDD.	"D8"	If send - Auto plug: "D8"
			03	Initial Treatment Date (for Spinal Manipulation)	R			Initial Treatment Date (for Spinal Manipulation) - date applies to all lines in the claim unless there is a date at the service line level.	?	Assigned by Sender
deleted		DTP		Referral Date - DELETED						
2300	186	DTP		Date - Date Last Seen	s			Required when claim involves services from an independent physical therapist, occupational therapist or physician services involving routine foot care and it is known to impact the payer's adjudication.	?	Send if known
			01	Date Time Qualifier	R			Date Time Qualifier, use	"	If sent - Auto plug: "304"
			02	Date Time Period Format Qualifier	R			Code indicating format of time, use "D8" for CCYYMMDD.	"D8"	If sent - Auto plug: "D8"
			03	Date Last Seen	R			Date Last Seen - date applies to all lines in the claim unless there is a date at the service line level.	?	Assigned by Sender
2300	188	DTP		Date - Onset of Current Illness/Symptom	s			Required when available and different from the date of service.		Send if known
			01	Date Time Qualifier	R			Date Time Qualifier, use "431"	"431"	If sent - Auto plug: "431"
			02	Date Time Period Format Qualifier	R			Code indicating format of time, use "D8" for CCYYMMDD.	"D8"	If sent - Auto plug: "D8"
			03	Onset of Current Illness / Symptom	R			Onset of Illness - date applies to all lines in the claim unless there is a date at the service line level.	box 14	Assigned by Sender
2300	190	DTP		Date - Acute Manifestation	s			Required when loop 2300 CR208 is "A" or "M", spinal manipulation and payer is Medicare.	?	Send if known
			01	Date Time Qualifier	R			Date Time Qualifier, use "453"	"453"	If sent - Auto plug: "453"
			02	Date Time Period Format Qualifier	R			Code indicating format of time, use "D8" for CCYYMMDD.	"D8"	If sent - Auto plug: "D8"
			03	Acute Manifestation Date	R			Acute Manifestation Date - date applies to all lines in the claim unless there is a date at the service line level.	?	Assigned by Sender
2300	192	DTP		Date - Similar Illness/Symptom Onset	s			Required when claim involves symptoms similar/identical to previously reported symptoms.		Send if known
			01	Date Time Qualifier	R			Date Time Qualifier, use "438"	"438"	If sent - Auto plug: "438"

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			02	Date Time Period Format Qualifier	R			Code indicating format of time, use "D8" for CCYYMMDD.	"D8"	If sent - Auto plug: "D8"
			03	Similar Illness or Symptom Date	R			Similar Illness or Symptom Date - date applies to all lines in the claim unless there is a date at the service line level.	box 15	Assigned by Sender. Could use box # 15.
2300	194	DTP		Date - Accident	s			Required if there is a related cause of auto accident, abuse, another responsible party or accident (indicated in CLM11-1, CLM11-2 or CLM11-3).	?	AHCCCS will edit this if CLM11-1, CLM11-2, or CLM11-3 being sent. Expect valid date if sent.
			01	Date Time Qualifier	R			Date Time Qualifier, use "439"	"439"	If sent - Auto plug: "439"
			02	Date Time Period Format Qualifier	R			Code indicating format of time, use "D8" for CCYYMMDD.	"D8"	If sent - Auto plug: "D8"
			03	Accident Date	R			Accident Date - date applies to all lines in the claim unless there is a date at the service line level.	box 14	Assigned by Sender. Could use box # 14.
2300	196	DTP		Date - Last Menstrual Period	s			Required when claim involves pregnancy.	?	Send if known
			01	Date Time Qualifier	R			Date Time Qualifier, use "484"	"484"	If sent - Auto plug: "484"
			02	Date Time Period Format Qualifier	R			Code indicating format of time, use "D8" for CCYYMMDD.	"D8"	If sent - Auto plug: "D8"
			03	Last Menstrual Period	R			Last Menstrual Period - date applies to all lines in the claim unless there is a date at the service line level.	box 14	Assigned by Sender. Could use box # 14.
2300	197	DTP		Date - Last X-ray	s			Required when claim involves spinal manipulation if an x-ray was taken.	?	Send if known
			01	Date Time Qualifier	R			Date Time Qualifier, use "455"	"455"	If sent - Auto plug: "455"
			02	Date Time Period Format Qualifier	R			Code indicating format of time, use "D8" for CCYYMMDD.	"D8"	If sent - Auto plug: "D8"
			03	Last X-ray Date	R			Last X-ray Date - date applies to all lines in the claim unless there is a date at the service line level.	?	Assigned by Sender.
deleted		DTP		Date - Estimated Date of Birth - DELETED						
2300	200	DTP		Date - Hearing/Vision Prescription Date	s			Required when a prescription has been written for hearing devices or vision glasses billed on the claim.	?	
			01	Date Time Qualifier	R			Date Time Qualifier, use "471"	"471"	If sent - Auto plug: "471"
			02	Date Time Period Format Qualifier	R			Code indicating format of time, use "D8" for CCYYMMDD.	"D8"	If sent - Auto plug: "D8"
			03	Prescription Date for Hearing or Vision	R			Prescription Date for Hearing or Vision - date applies to all lines in the claim unless there is a date at the service line level.	?	Assigned by Sender.
2300	201	DTP		Date - Disability Begin Date	s			Required on claims involving disability when patient will be unable to perform normal job duties. Not required for HIPAA but may be required for other uses.		Send it if applicable
			01	Date Time Qualifier	R			Date Time Qualifier, use "360"	"360"	If sent - Auto plug: "360"
			02	Date Time Period Format Qualifier	R			Code indicating format of time, use "D8" for CCYYMMDD.	"D8"	If sent - Auto plug: "D8"
			03	Disability Begin Date	R			Disability Begin Date - date applies to all lines in the claim unless there is a date at the service line level.	box 16	Assigned by Sender. Could use box # 16
2300	203	DTP		Date - Disability End Date	s			Required on claims involving disability when patient will be able to perform normal job duties. Not required for HIPAA but may be required for other uses.		Send it if applicable
			01	Date Time Qualifier	R			Date Time Qualifier, use "361"	"361"	If sent - Auto plug: "361"
			02	Date Time Period Format Qualifier	R			Code indicating format of time, use "D8" for CCYYMMDD.	"D8"	If sent - Auto plug: "D8"

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			03	Disability End Date	**R**			Disability End Date - date applies to all lines in the claim unless there is a date at the service line level.	**box 16**	**Assigned by Sender. Could use box # 16**
2300	**205**	**DTP**		Date - Last Worked	**s**			Required on claims where this info is needed for claim adjudication (e.g. worker's compensation claims involving absence from work).	**?**	**Send it if applicable**
			01	Date Time Qualifier	**R**			Date Time Qualifier, use "297"	**"297"**	**If sent - Auto plug: "297"**
			02	Date Time Period Format Qualifier	**R**			Code indicating format of time, use "D8" for CCYYMMDD.	**"D8"**	**If sent - Auto plug: "D8"**
			03	Last Worked Date	**R**			Last Worked Date - date applies to all lines in the claim unless there is a date at the service line level.	**?**	**Assigned by Sender**
2300	**206**	**DTP**		Date - Authorized Return to Work	**s**			Required on claims where this info is needed for claim adjudication (e.g. worker's compensation claims involving absence from work).	**?**	**Send it if applicable**
			01	Date Time Qualifier	**R**			Date Time Qualifier, use "296"	**"296"**	**If sent - Auto plug: "296"**
			02	Date Time Period Format Qualifier	**R**			Code indicating format of time, use "D8" for CCYYMMDD.	**"D8"**	**If sent - Auto plug: "D8"**
			03	Work Return Date	**R**			Work Return Date - date applies to all lines in the claim unless there is a date at the service line level.	**?**	**Assigned by Sender**
2300	**208**	**DTP**		Date - Admission	**s**			Required on all ambulance claims/encounters when the patient was known to be admitted to hospital? Also required on inpatient claims/encounters.		**Send it if applicable**
			01	Date Time Qualifier	**R**			Date Time Qualifier, use "435"	**"435"**	**If sent - Auto plug: "435"**
			02	Date Time Period Format Qualifier	**R**			Code indicating format of time, use "D8" for CCYYMMDD.	**"D8"**	**If sent - Auto plug: "D8"**
			03	Related Hospitalization Admission Date	**R**			Related Hospitalization Admission Date - date applies to all lines in the claim unless there is a date at the service line level.	**box 18**	**Assigned by Sender. Could use box # 18**
2300	**210**	**DTP**		Date - Discharge	**s**			Required for inpatient claims when patient is discharged from the facility.		**Send it if applicable**
			01	Date Time Qualifier	**R**			Date Time Qualifier, use "096"	**"096"**	**If sent - Auto plug: "096"**
			02	Date Time Period Format Qualifier	**R**			Code indicating format of time, use "D8" for CCYYMMDD.	**"D8"**	**If sent - Auto plug: "D8"**
			03	Related Hospitalization Discharge Date	**R**			Related Hospitalization Discharge Date - date applies to all lines in the claim unless there is a date at the service line level.	**box 18**	**Assigned by Sender. Could use box # 18**
2300	**212**	**DTP**		Date - Assumed and Relinquished Care Dates	**s**			Required on Medicare claims when providers share post-operative care (global surgery claims).	**?**	**Send it if applicable**
			01	Date Time Qualifier	**R**			Date Time Qualifier, use "090" for Assumed Care Date and "091" for Relinquished Care Date.	**?**	**If sent - Use: "090" for Assumed Care Date. Use: "091" for Relinquished Care Date.**
			02	Date Time Period Format Qualifier	**R**			Code indicating format of time, use "D8" for CCYYMMDD.	**"D8"**	**If sent - Auto plug: "D8"**
			03	Assumed and Relinquished Care Dates	**R**			Assumed and Relinquished Care Dates - date applies to all lines in the claim unless there is a date at the service line level.	**?**	**Assigned by Sender**
2300	**214**	**PWK**		Claim Supplemental Info	**s**			Required to: 1) to inform that there is paper documentation supporting this claim, 2) to identify electronic attachments or 3) to identify paperwork that is being held at the provider's office.	**?**	Issue Data from this segment can be used when audits detect service maximums exceeded. AHCCCS needs further discussion and report back to Workgroup

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			01	Attachment Report Type Code	R			Code indicating the title or contents of a supporting item. Refer to table on page 215 of the TIG.	?	Send if applicable. Select appropriate HIPAA value
			02	Attachment Transmission Code	R			Code defining timing, transmission, etc. for supplemental information.	?	Send if applicable. Select appropriate HIPAA value
			05	ID Code Qualifier	s			Code designating the system/method of code structure used for ID Code. Use "AC".	"AC"	If sent, auto plug: "AC"
			06	Attachment Control Number				Attachment Control Number	?	If PWK02 = "AA", this element is not required. Otherwise, send if applicable.
2300	217	CN1		Contract Info	s			Recommended that submitters include the CN1 segmentfor encounters that include only capitated services. Required if the provider is contractually obligated to provide contract information on this claim.	?	
			01	Contract Type Code	R			Code identifying a contract type, refer to table on page 217 of TIG.	?	Expect the Sub Cap Code in this element. Use appropriate HIPAA value
			02	Contract Amount	s			Required if the provider is required by contract to supply this information on the claim.	?	Not Needed
			03	Contract Percent	s			Allowance or charge percent. Required if the provider is required by contract to supply this information on the claim.	?	Not Needed
			04	Contract Code	s			Required if the provider is required by contract to supply this information on the claim.	?	Not Needed
			05	Terms Discount Percent	s			Required if the provider is required by contract to supply this information on the claim.	?	Not Needed
			06	Contract Version ID	s			Required if the provider is required by contract to supply this information on the claim.	?	Not Needed
2300	219	AMT		Credit/Debit Card Max Amount				This info is never sent to the payer :: neither PHS nor AHCCCS should receive this info. This info is strictly for use between a provider and a service organization.		AHCCCS does not expect this segment
2300	220	AMT		Patient Amount Paid	s			Required if the patient has paid any amount towards the claim.		This segment is not applicable to AHCCCS
			01	Amount Qualifier Code	R			Code to qualify amount, use "F5" for Patient Amount Paid.	"F5"	Not Needed
			02	Patient Amount Paid	R			Patient Amount Paid	box 29	Not Needed
2300	221	AMT		Total Purchased Service Amount	s			Required if there are purchased service components to this claim. Use this segment on vision claims when the acquisition cost of lenses is known to impact adjudication or reimbursement.	?	Send if known. Workgroup question: How pre/post Natal Care being billed?
			01	Amount Qualifier Code	R			Code to qualify amount, use "NE" for Patient Amount Paid.	"NE"	If sent, auto plug: "NE"
			02	Total Purchased Service Amount	R			Total Purchased Service Amount	?	Assigned by Sender if applicable
2300	222	REF		Service Authorization Exception Code	s			Required when a provider must obtain authorization for specific services but performed the service without obtaining it.	?	
			01	Reference ID Qualifier	R			Code qualifying the Reference ID, use "4N" for Special payment Reference Number.	"4N"	If sent, auto plug: "4N"
			02	Service Authorization Exception Code	R			Reference information as defined for a particular Transaction Set. Refer to chart on page 223 in TIG.	?	Assigned by Sender if applicable

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
2300	**224**	**REF**		Mandatory Medicare (Section 4081) Crossover Indicator	**s**			Completed by Medicare.		
			01	Reference ID Qualifier	**R**			Code qualifying the Reference ID, use "F5" for Medicare Version Code	**"F5"**	**If sent, auto plug: "F5"**
			02	Medicare Section 4081 Indicator	**R**			Medicare Section 4081 Indicator	**?**	The allowed values for this element are: Y 4081 (NSF Value 1) N Regular crossover (NSF Value 2)
2300	**226**	**REF**		Mammography Certification Number	**s**			Required when mammography services are rendered by a certified mammography provider.	**?**	Issue: MCOs may not have this - both Mammography Cert # and CLIA # can be derived from full Provider File that AHCCCS sends to MCOs each month. AHCCCS will need further research on this
			01	Reference ID Qualifier	**R**			Code qualifying the Reference ID, use "EW" for Mammography Certification Number.	**"EW"**	**If sent, auto plug: "EW"**
			02	Mammography Certification Number	**R**			Mammography Certification Number	**?**	**Expect Mammography Certification Number if applicable.**
2300	**227**	**REF**		Prior Authorization/Referral Number	**s**			Required for claims having a referral (require preauthorization).		
			01	Reference ID Qualifier	**R**			Code qualifying the Reference ID, use "9F" for Referral Number or "G1" for Prior Authorization Number.	**? "G1" or "9F"**	**If sent, auto plug: "G1" or "9F" whichever applicable.**
			02	Prior Authorization/Referral Number				Prior Authorization/Referral Number	**box 23**	**Expect Referral Number or PA Number, if applicable.**
2300	**229**	**REF**		Original Reference Number (ICN/DCN)	**s**			Required for claims being re-submitted.	**? Box 22**	
			01	Reference ID Qualifier	**R**			Code qualifying the Reference ID, use "F8"	**"F8"**	**If sent, auto plug: "F8"**
			02	Claim Original Reference Number (ICN/DCN)	**R**			Claim Original Reference Number (ICN/DCN)	**? Box 22**	**Expect AHCCCS Original CRN that is to be Voided or Replaced in this element, if applicable.**
2300	**231**	**REF**		Clinical Laboratory Improvement Amendment Number	**s**			Required on Medicare and Medicaid claims for any lab tests covered by the CLIA Act.	**?**	Issue: MCOs may not have this - both Mammography Cert # and CLIA # can be derived from full Provider File that AHCCCS sends to MCOs each month. AHCCCS will need further research on this
			01	Reference ID Qualifier	**R**			Code qualifying the Reference ID, use "X4"	**"X4"**	**If sent, auto plug: "X4"**
			02	Clinical Laboratory Improvement Amendment Number	**R**			Clinical Laboratory Improvement Amendment Number	**?**	**Expect CLIA certification number, if applicable.**
2300	**233**	**REF**		Repriced Claim Number	**s**			Used by repricers as needed (specific to destination payer in 2010BB loop).	**?**	**Not Required**
			01	Reference ID Qualifier	**R**			Code qualifying the Reference ID, use "9A"	**"9A"**	**Not Required**
			02	Repriced Claim Reference Number	**R**					**Not Required**
2300	**235**	**REF**		Adjusted Repriced Claim Number	**s**			Used by repricers as needed (specific to destination payer in 2010BB loop).	**?**	**Not Required**
			01	Reference ID Qualifier	**R**			Code qualifying the Reference ID, use "9C"	**"9C"**	**Not Required**

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			02	Adjusted Repriced Claim Number	R			Adjusted Repriced Claim Number	?	Not Required
2300	236	REF		Investigational Device Exemption Number	s			Required when claim involves an FDA assigned investigational device exemption (IDE) number. Only one IDE per claim is to be reported.	?	Not Required
			01	Reference ID Qualifier	R			Code qualifying the Reference ID, use "LX"	"LX"	Not Required
			02	Investigational Device Exemption Number	R			Investigational Device Exemption Number	?	Not Required
2300	238	REF		Claim ID Number for Clearinghouses and Other Trans Intermediaries	s			Used by transmission intermediaries for their own unique claim number.		Not Required
2300	240	REF		Ambulatory Patient Group	s			Required if the contract between provider and payer is based on APG and provider must send APG information on claim.	?	Not Required
			01	Reference ID Qualifier	R			Code qualifying the Reference ID, use "1S"	"1S"	Not Required
			02	Ambulatory Patient Group	R			Ambulatory Patient Group	?	Not Required
2300	241	REF		Medical Record Number	s			Used at the discretion of the submitter.	?	Not Required
			01	Reference ID Qualifier	R			Code qualifying the Reference ID, use "EA"	"EA"	Not Required
			02	Medical Record Number	R			Medical Record Number	?	Not Required
2300	242	REF		Demonstration Project ID	s			Required on claims where a demonsration project is being billed/reported.	?	Not Required
			01	Reference ID Qualifier	R			Code qualifying the Reference ID, use "P4"	"P4"	Not Required
			01	Demonstration Project ID	R			Demonstration Project ID	?	Not Required
2300	244	K3		File Info	s			not used at this time		Not to be used at this time
2300	246	NTE		Claim Note	s			use not recommended		Not to be used at this time
2300	248	CR1		Ambulance Transport Info	s			Required on all claims involving ambulance services.	?	
			01	Unit or Basis for Measurement Code	s			Code specifying the units in which a value is being expressed. Required if needed to justify extra ambulance services.	"LB"	If sent, auto plug: "LB"
			02	Patient Weight	s			Patient Weight in pounds	?	Expect Patient Weight if applicable
			03	Ambulance Transport Code	R			Ambulance Transport Code indicates the type of ambulance transport. Refer to chart on pages 249-250 of TIG.	?	Select appropriate HIPAA value if applicable
			04	Ambulance Transport Reason Code	R			Ambulance Transport Reason Code	?	Select appropriate HIPAA value if applicable
			05	Unit or Basis for Measurement Code	R			Code specifying the units in which a value is being expressed. Use "DH" for Miles.	"DH"	If sent, auto plug: "DH"
			06	Transport Distance	R			Transport Distance	?	Expect Ambulance Miles in this field, if applicable.
			09	Round Trip Purpose Description	s			Round Trip Purpose Description. Required if CR1-03 (Ambulance Transport Code) = "X" (round trip)	?	Expect reason for round trip ambulance, if applicable.
			10	Stretcher Purpose Description	s			Stretcher Purpose Description. Required if needed to justify usage of stretcher.	?	Expect purpose for stretcher, if applicable.

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
2300	251	CR2		Spinal Manipulation Service Info	s	s		Required on chiropractic claims involving spinal manipulation known to impact payer's adjudication process.	?	This segment is not required. Send if known and applicable.
			01	Treatment Series Number	n	n		Treatment Number - Spinal Manipulation	?	Not used per Addenda
			02	Treatment Series Total	n	n		Treatment Series Total	?	Not used per Addenda
			03	Subluxation Level Code	n	n		Code identifying the specific level of subluxation. Refer to chart on pages 252-253 of the TIG.	?	Not used per Addenda
			04	Subluxation Level Code	n	n		Code identifying the specific level of subluxation. Refer to chart on pages 253-254 of the TIG.	?	Not used per Addenda
			05	Unit or Basis for Measurement Code	n	n		Code specifying the units in which a value is being expressed.	?	Not used per Addenda
			06	Treatment Period Count	n	n		Treatment Series Period - Spinal Manipulation	?	Not used per Addenda
			07	Treatment Number in Month - Spinal Manipulation (Monthly Treatment Count)	n	n		Treatment Number in Month - Spinal Manipulation (Monthly Treatment Count)	?	Not used per Addenda
			08	Patient Condition Code	R	R		Patient Condition Code - Spinal Manipulation	?	Select appropriate HIPAA value if applicable
			09	Complication Indicator - Spinal Manipulation	n	n		Complication Indicator - Spinal Manipulation	?	Not used per Addenda
			10	Patient Condition Description - Spinal Manipulation	s	s		Patient Condition Description - Spinal Manipulation	?	Expect description of patient's condition in this field, if applicable.
			11	Patient Condition Description - Spinal Manipulation	s	s		Patient Condition Description - Spinal Manipulation	?	Expect description of patient's condition in this field, if applicable.
			12	X-ray Availablility Indicator - Spinal Manipulation	s	s		X-ray Availablility Indicator - Spinal Manipulation. Required for service dates prior to January 1, 2000.	?	Select appropriate HIPAA value if applicable
2300	257	CRC		Ambulance Certification	s			Required on all claims involving ambulance services when CR1 segment is used.	?	
			01	Code Category	R			Code Category, use "07" for Ambulance Certification.	"07"	If sent, auto plug: "07"
			02	Certification Condition Code Applies Indicator	R			Certification Condition Code Applies Indicator. A "Y" value indicates that the condition codes in CRC03 through CRC-07 apply; an "N" value indicates the condition codes in CRC-03 through CRC-07 do not apply.	?	If sent, select appropriate HIPAA valid values
			03	Condition Code	R			Condition Code, refer to pages 258-259 in the TIG.	?	If sent, select appropriate HIPAA valid values
			04	Condition Code	s			Condition Code, refer to pages 258-259 in the TIG.	?	If sent, select appropriate HIPAA valid values
			05	Condition Code	s			Condition Code, refer to pages 258-259 in the TIG.	?	If sent, select appropriate HIPAA valid values
			06	Condition Code	s			Condition Code, refer to pages 258-259 in the TIG.	?	If sent, select appropriate HIPAA valid values
			07	Condition Code	s			Condition Code, refer to pages 258-259 in the TIG.	?	If sent, select appropriate HIPAA valid values

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
2300	**260**	**CRC**		Patient Condition Info: Vision	**s**			Required on vision claims involving replacement lenses or frames when this information is known to impact reimbursement.	**?**	**This segment is not required. Send if known and applicable.**
			01	Code Category	**R**			Specifies the situatio or category to which the code applies. CRC-01 qualifies CRC-03 through CRC-07. Use: "E1" for spectacle lenses, "E2" for contact lenses, "E3" for spectacle frames.	**?**	**Select appropriate HIPAA value if known and applicable**
			02	Certification Condition Code Applies Indicator	**R**			Certification Condition Code Applies Indicator. A "Y" value indicates that the condition codes in CRC03 through CRC-07 apply; an "N" value indicates the condition codes in CRC-03 through CRC-07 do not apply.	**?**	**Select appropriate HIPAA value if known and applicable**
			03	Condition Code	**R**			Condition Code, refer to page 261 in the TIG. Select code to indicate reason for replacement of vision aid.	**?**	**Select appropriate HIPAA value if known and applicable**
			04	Condition Code	**s**			Condition Code	**?**	**Send only if additional condition codes are needed. Select appropriate HIPAA value if known and applicable.**
			05	Condition Code	**s**			Condition Code	**?**	**Send only if additional condition codes are needed. Select appropriate HIPAA value if known and applicable.**
			06	Condition Code	**s**			Condition Code	**?**	**Send only if additional condition codes are needed. Select appropriate HIPAA value if known and applicable.**
2300	**263**	**CRC**		Homebound Indicator	**s**			Required for Medicare claims when an independent lab renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient.	**?**	**This segment is not required. Send if known and applicable.**
			01	Code Category	**R**			Code Category, use "75" for Functional Limitations.	**?**	**Select appropriate HIPAA value if known and applicable**
			02	Certification Condition Indicator	**R**			CRC-02 is a Certification Condition Code applies indicator. A "Y" value indicates the condition codes in CRC-03 through CRC-07 apply.	**"Y"**	**Select appropriate HIPAA value if known and applicable**
			03	Homebound Indicator	**R**			Homebound Indicator, use "IH" for Independent at Home.	**"IH" if member is homebound**	**Select appropriate HIPAA value if known and applicable**
2300		**CRC**		EPSDT Referral	**s**			Required on early and period screening diagnosis and treatment claims/encounters.		
new segment			**01**	Code Category	**R**			Use "ZZ" for Mutually Defined.	**"ZZ"**	**If send, auto plug: "ZZ"**
			02	Certification Condition Code Applies Indicator	**R**			Use "Y" for Yes or "N" for No. Was an EPSDT referral given to the patient?	**?**	**Select appropriate HIPAA value if known and applicable**
			03	Condition Indicator	**R**					**Select appropriate HIPAA value if known and applicable**
			04	Condition Code	**s**					**Send only if additional condition codes are needed. Select appropriate HIPAA value if known and applicable.**

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			05	Condition Code	**s**					**Send only if additional condition codes are needed. Select appropriate HIPAA value if known and applicable.**
2300	**265**	**HI**		Healthcare Diagnosis Code	**s**			Required on all claims having diagnoses.		
			01	Principal Diagnosis	**R**			Principal Diagnosis. It is not recommended to use E codes in HI-01. E codes may be put in any other HI element using BF as the qualifier.	**box 21**	
			01-1	Diagnosis Type Code	**R**			Diagnosis Type Code, use "BK" for principal diagnosis.	**"BK"**	**Auto plug: "BK"**
			01-2	Diagnosis Code	**R**			Diagnosis Code	**box 21**	**Expect ICD-9 Principal Diagnosis Code**
			02	Diagnosis	**s**			Required if needed to report an additional diagnosis and if the preceeding HI data elements have been used to report other diagnoses.	**box 21**	
			02-1	Diagnosis Type Code	**R**			Diagnosis Type Code, use "BF" for diagnosis.	**"BF"**	**Auto plug: "BF"**
			02-2	Diagnosis Code	**R**			Diagnosis Code		**Expect ICD-9 Diagnosis Code if known**
			03	Diagnosis	**s**			Required if needed to report an additional diagnosis and if the preceeding HI data elements have been used to report other diagnoses.		
			03-1	Diagnosis Type Code	**R**			Diagnosis Type Code, use "BF" for diagnosis.		**Auto plug: "BF"**
			03-2	Diagnosis Code	**R**			Diagnosis Code		**Expect ICD-9 Diagnosis Code if known**
			04	Diagnosis	**s**			Required if needed to report an additional diagnosis and if the preceeding HI data elements have been used to report other diagnoses.		
			04-1	Diagnosis Type Code	**R**			Diagnosis Type Code, use "BF" for diagnosis.		**Auto plug: "BF"**
			04-2	Diagnosis Code	**R**			Diagnosis Code		**Expect ICD-9 Diagnosis Code if known**
			05	Diagnosis	**s**			Required if needed to report an additional diagnosis and if the preceeding HI data elements have been used to report other diagnoses.		
			05-1	Diagnosis Type Code	**R**			Diagnosis Type Code, use "BF" for diagnosis.		**Auto plug: "BF"**
			05-2	Diagnosis Code	**R**			Diagnosis Code		**Expect ICD-9 Diagnosis Code if known and applicable**
			06	Diagnosis	**s**			Required if needed to report an additional diagnosis and if the preceeding HI data elements have been used to report other diagnoses.		
			06-1	Diagnosis Type Code	**R**			Diagnosis Type Code, use "BF" for diagnosis.		**Auto plug: "BF"**
			06-2	Diagnosis Code	**R**			Diagnosis Code		**Expect ICD-9 Diagnosis Code if known and applicable**
			07	Diagnosis	**s**			Required if needed to report an additional diagnosis and if the preceeding HI data elements have been used to report other diagnoses.		
			07-1	Diagnosis Type Code	**R**			Diagnosis Type Code, use "BF" for diagnosis.		**Auto plug: "BF"**
			07-2	Diagnosis Code	**R**			Diagnosis Code		**Expect ICD-9 Diagnosis Code if known and applicable**

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
2300	**271**	**HCP**		Claim Pricing/Repricing Info	**s**			Used only by repricers as needed. For capitated encounters, pricing or repricing information usually is not applicable and is provided to qualify other information within the claim.	-	
2305		**Home Health Care Plan Info**			**s**			Required on home health claims that involve billing/reporting home health visits.	?	
2305	**276**	**CR7**		Home Health Care Plan Info	**s**			Required on home health claims that involve billing/reporting home health visits.	?	
			01	Discipline Type Code	**R**			Code indicating disciplines ordered by a physician.	?	**Select appropriate HIPAA value if known and applicable**
			02	Total Visits Rendered - Home Health	**R**			Total Visits Rendered - Home Health. CR7-02 is the total visits on this bill rendered prior to the recertification "to" date.	?	**If sent, expect Total Home Health Visits rendered.**
			03	Total Visits Projected - Home Health	**R**			Total Visits Projected - Home Health	?	**If sent, expect Total Home Health Visits projected**
2305	**278**	**HSD**		Healthcare Services	**s**			Required on claims billing/reporting home health visits where further detail is necessary to clearly substantiate medical treatment.	?	
			01	Visits	**s**			Code specifying the type of quantity, use "VS" for Visits'	**"VS"**	**If sent, auto plug: "VS"**
			02	Number of Visits	**s**			Number of Visits. Required if the order/prescription for the service contains the data.	?	**Expect number of visits expected during certification period in this field, if applicable.**
			03	Frequency Period	**s**			Frequency Period. Required if the order/prescription for the service contains the data. Use: "DA" for Days, "MO" for Months, "Q1" for Quarter (Time), "WK" for Week.	?	**Select appropriate HIPAA value if known and applicable**
			04	Frequency Count	**s**			Frequency Count. Required if the order/prescription for the service contains the data.	?	**Expect Frequency count if known and applicable.**
			05	Duration of Visits Units	**s**			Duration of Visits Units. Required if the order/prescription for the service contains the data. Use: "7" for Day, "35" for Week.	?	**Select appropriate HIPAA value if known and applicable**
			06	Duration of Visits - Number of Units	**s**			Duration of Visits - Number of Units	?	**Expect Duration of Visits, Number of Units if known and applicable**
			07	Pattern Code	**s**			Pattern Code. Required if the order/prescription for the service contains the data. Refer to chart on pages 280-281 on TIG.	?	**Select appropriate HIPAA value if known and applicable**
			08	Delivery Pattern Time Code	**s**			Delivery Pattern Time Code	?	**Select appropriate HIPAA value if known and applicable**
2310A		**Referring Provider Name**			**s**			Required if claim involved a referral.	-	
2310A	**282**	**NM1**		Referring Provider Name	**s**			Required if claim involved a referral.		**Send if known and applicable**
			01	Name of Referring Provider or PCP Entity Type Code	**R**			Name of Referring Provider or PCP Entity Type Code. Use "DN" for Referring Provider, "P3" for PCP.	**box 17 ?**	**Select appropriate HIPAA value if known and applicable**
			02	Entity Type Qualifier	**R**			Use: "1" for Person, "2" for Non-person entity.	?	**If send, auto plug: "1" - Person**
			03	Referring Provider Last Name	**R**			Referring Provider Last Name	**box 17**	**If sent, expect Referring Provider Last Name**
			04	Referring Provider First Name	**s**			Referring Provider First Name	**box 17**	**If sent, expect Referring Provider First Name if known**
			05	Referring Provider Middle Name	**s**			Referring Provider Middle Name	**box 17**	**If sent, expect Referring Provider First Name if known**

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			07	Referring Provider Name Suffix	s			Referring Provider Name Suffix	box 17	This element is not required. Send if known.
			08	ID Code Qualifier	s			ID Code Qualifier, use: "24" for EIN, "34" for SSN, "XX" for HCFA national provider ID.	?	If send, use '24" or "34" whichever applicable
			09	Referring Provider ID	s			Referring Provider ID	box 17a	Expect Referring Provider's SSN or Employer ID in this field, if applicable.
2310A	285	PRV		Referring Provider Specialty Info	s			Required when adjudication is known to be impacted by provider taxonomy code.	?	The PRV Segment will not be used. Taxonomy use changed by Addenda.
			01	Provider Code	R			Provider Code, use "RF" for Referring.	"RF"	This element is not required
			02	Reference ID Qualifier	R			"ZZ" is used to indicate the "Health Care Provider Taxonomy" code list of provider specialties.	"ZZ"	This element is not required
			03	Provider Specialty Code	R			Provider Specialty Code	?	This element is not required
2310A	288	REF		Referring Provider Secondary ID	s			Required if secondary identification is needed. Required under certain circumstances.	?	
			01	Reference ID Qualifier	R			Code qualifying the Reference ID. Refer to chart on pages 288 289 in the TIG.	?	Auto plug: "1D"
			02	Referring Provider Secondary ID	R			Referring Provider Secondary ID	?	AHCCCS Provider ID
2310B	**290**	**Rendering Provider Name**			s			Required if the rendering provider is different from the Billing provider and the Pay-to provider.	-	
2310B	290	NM1		Rendering Provider Name	s			Required if the rendering provider is different from the Billing provider and the Pay-to provider.		Send if Rendering Provider is different than Billing Provider
			01	Entity ID Code	R			Code identifying individual or entity, use "82" for Rendering Provider.	"82"	If sent, auto plug: "82"
			02	Entity Type Qualifier	R			Use "1" for Person, "2" for entity.	?	If sent, expect HIPAA valid value
			03	Rendering Provider Last Name or Organization Name	R			Rendering Provider land Name or Organization Name	box 31	If sent, expect Rendering Provider Last Name
			04	Rendering Provider First Name	s			Rendering Provider First name	box 31	If sent, expect Rendering Provider First Name
			05	Rendering Provider Middle Name	s			Rendering Provider Middle Name	box 31	If sent, expect Rendering Provider Middle Name
			07	Rendering Provider Name Suffix	s			Rendering Provider Name Suffix	box 31	This element is not required. Send if known.
			08	ID Code Qualifier	R			Code designating the system used for identification, use: "24" for EIN, "34" for SSN, "XX" for HCFA national provider ID.	"24" or "34" per box 25	If sent, use '24" or "34" whichever applicable
			09	Rendering Provider Primary ID Number	R			Rendering Provider Primary ID Number	box 25	Expect Service Provider's SSN or Employer ID in this field, if applicable.
usage changed to S	293	PRV		Rendering Provider Specialty Info	s			Required when adjudication is known to be impacted by provider taxonomy code.	?	The PRV Segment will not be used. Taxonomy use changed by Addenda.
			01	Provider Code	R			Code identifying the type of provider, use "PE" for Performing.	"PE"	This element is not required
			02	Reference ID Qualifier	R			Reference ID Qualifier. "ZZ" is used to indicate the "Health Care Provider Taxonomy" provider specialty code list.	"ZZ"	This element is not required

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			03	Rendering Provider Specialty Code	R			Rendering Provider Specialty Code	?	This element is not required
2310B	296	REF		Rendering Provider Secondary ID	s			Required if secondary identification is needed.	?	
			01	Reference ID Qualifier	R			Code qualifying the Reference ID. Refer to chart on pages 296 297 in the TIG.		Auto plug: "1D"
			02	Rendering Provider Secondary ID	R			Rendering Provider Secondary ID	box 33 PIN # (is the AHCCCS ID)	AHCCCS Provider ID
2310C		**Purchased Service Provider Name**			s			required if purchased services are bing billed/reported on this claim.	-	
2310C	298	NM1		Purchased Service Provider Name	s			Required if purchased services are bing billed/reported on this claim.	?	
			01	Entity ID Code	R			Code identifying an organization or a person, use "QB" for Purchase Service Provider.	"QB"	If sent, auto plug: "QB"
			02	Entity Type Qualifier	R			Use "1" for Person, "2" for entity.	?	If sent, expect HIPAA valid value
			03	Last Name or Organization Name	R				?	If sent, expect Purchased Provider Last Name or Organization Name
			04	First Name	s				?	If sent, and NM102 = "1", expect Purchased Provider First Name.
			05	Middle Name	s				?	If sent, and NM102 = "1", expect Purchased Provider Middle Name if known
			08	ID Code Qualifier	s			Code designating the system of ID code, use: "24" for EIN, "34" for SSN, "XX" for HCFA national provider ID.	?	If sent, use '24" or "34" whichever applicable
			09	Purchased Service Provider Primary ID	s			Purchased Service Provider Primary ID	?	Expect Service Provider's SSN or Employer ID in this field, if applicable.
2310C	301	REF		Purchased Service Provider Secondary ID	s			Required if secondary identification is needed.	?	This segment is sent if applicable
			01	Reference ID Qualifier	R			Code qualifying the Reference ID. Refer to chart on pages 301 302 of TIG.	?	Auto plug: "1D"
			02	Purchased Service Provider Secondary ID	R			Purchased Service Provider Secondary ID	?	The AHCCCS ID and Service Locator Code for the Purchased Service Provider
2310D		**Service Facility Location**			s			Required if the service location is different from the billing provider's location and the pay-to provider's location.	-	
2310D	303	NM1		Service Facility Location	s			Required if the service location is different from the billing provider's location and the pay-to provider's location.		
			01	Entity ID Code	R			Code identifying an entity or person, use: "77" for Service Location, "FA" for Facility, "LI", Independent Lab, "TL" for Testing Laboratory. Use "77" if no other code applies.	?	If sent, expect applicable HIPAA valid value
			02	Entity Type Qualifier	R			Use: "1" for Person, "2" for Non-person entity. Assumption: facility is a non-person entity.	"2"	If sent, auto plug: "2"
			03	Laboratory or Facility Name	s			Laboratory or Facility Name	box 32	If send, expect applicable Laboratory/Facility Namet
			08	ID Code Qualifier	s			Use: "24" for EIN, "34" for SSN, "XX" for HCFA national provider ID.	?	If sent, use '24" or "34" whichever applicable

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			09	Laboratory of Facility Primary ID	s			Laboratory of Facility Primary ID	?	Expect Service Provider's SSN or Employer ID in this field, if applicable.
2310D	307	N3		Service Facility Location Address	R				box 32	
			01	Lab or Facility Address Line 1	R			Lab or Facility Address Line 1	box 32	If sent, expect Facility Street Address
			02	Lab or Facility Address Line 2	s			Lab or Facility Address Line 2	box 32	Send this element only if needed a 2nd line for Street Address
2310D	308	N4		Service Facility Location City/State/Zip	R				box 32	
			01	Lab/Facility City	R			Lab/Facility City	box 32	If sent, expect Lab/Facility City Name
			02	Lab/Facility State	R			Lab/Facility State	box 32	If sent, expect Lab/Facility State Code
			03	Lab/Facility Zip code	R			Lab/Facility Zip code	box 32	If sent, expect Lab/Facility Zip Code
			04	Lab/Facility Country Code	s			Lab/Facility Country Code	box 32	This element is not required
2310D	310	REF		Service Facility Location Secondary ID	s			Required if secondary identification is needed.	?	
			01	Reference ID Qualifier	R			Code qualifying the Reference ID. Refer to chart on pages 310 311 in the TIG.	?	Auto plug: "1D"
			02	Lab/Facility Secondary ID Number	R			Lab/Facility Secondary ID Number	?	Expect the AHCCCS ID and Service Locator Code of the Facility or Laboratory Provider in this field, if applicable.
2310E		Supervising Provider Name			s			Required when the rendering provider is supervised by a physician.	-	
2310E	312	NM1		Supervising Provider Name	s			Required when the rendering provider is supervised by a physician.	?	Send this segment if known and applicable
			01	Entity ID Code	R			Use "DQ" for Supervising Physician.	"DQ"	If sent, auto plug: "DQ"
			02	Entity Type Qualifier	R			Use "1" for Person, "2" for entity.	"1"	If sent, auto plug: "1"
			03	Supervising Provider Last Name	R			Supervising Provider Last Name	?	If sent, expect Supervising Provider Last Name
			04	Supervising Provider First Name	R			Supervising Provider First Name	?	If sent, expect Supervising Provider First Name
			05	Supervising Provider Middle Name	s			Supervising Provider Middle Name	?	This element is not required. If sent, expect Supervising Provider Middle Name
			07	Supervising Provider Name Suffix	s			Supervising Provider Name Suffix	?	This element is not required. Send if known.
			08	ID Code Qualifier	s			Use: "24" for EIN, "34" for SSN, "XX" for HCFA national provider ID.	?	If sent, use '24" or "34" whichever applicable
			09	Supervising Provider Primary ID	s			Supervising Provider Primary ID	?	Expect Service Provider's SSN or Employer ID in this field, if applicable.
2310E	316	REF		Supervising Provider Secondary ID	s			Required if secondary identification is needed.	?	
			01	Reference ID Qualifier	R			Code qualifying the Reference ID, refer to pages 316-317 of the TIG.	?	Auto plug: "1D"

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			02	Supervising Provider Sedondary ID	R			Supervising Provider Sedondary ID	?	Expect the AHCCCS ID and Service Locator Code for the Supervising Provider in this field, if applicable.
2320		Other Subscriber Info			s			Required if other payers are known to potentially be involved in paying on this claim.	-	Will expect at least one occurrence of this loop with Health Plan as Payer in 2330A and 2330B.
2320	318	SBR		Other Subscriber Info	s			Required if other payers are known to potentially be involved in paying on this claim.		
			01	Payer responsibility Sequence Number	R			Use: "P" for Primary, "S" for Secondary, "T" for Tertiary.	?	Select valid applicable HIPAA code value
			02	Individual Relationship Code	R			See chart on pages 319-320 of the TIG.	?	Select valid applicable HIPAA code value (for the MCO 2320 loop this would be "18")
			03	Other Insured Group or Policy Number	s			Required if the subscriber's payer ID includes Group or Plan Number.	box 9a	Expect one occurrence with Health Plan ID and TSN if others then Group or Plan Number in this field, if applicable.
			04	Other Insured Group Name	s			Required if the subscriber's payer ID includes Group or Plan Name	box 9d ?	Health Plan, Group or Policy Name should appear in this field, if applicable.
			05	Insurance Type code	R			Code identifying the type of insurance policy within a specific insurance program		For Health Plan occurrence expect value "HM". Use "OT" (Other) in this field", if other occurrences or expect valid applicable HIPAA value in this field.
			09	Claim Filing Indicator Code	s			Required prior to mandated use of PlanID. Not used after PlanID is mandated. Refer to chart on pages 321-322 of the TIG.	?	If sent, use '11'.
2320	323	CAS		Claim Level Adjustments	s			Required if claim has been adjudicated by payer and has claim level adjustment information.	?	Send this segment if known and applicable
			01	Claim Adjustment Group Code	R			Code identifying the general ategory of payment adjustment.	?	Select valid applicable HIPAA code value
			02	Adjustment Reason Code - Claim Level	R			Code identifying the detailed reason the adjustment was made.	?	Select valid applicable HIPAA code value
			03	Adjustment Amount - Claim Level	R			Amount of the Adjustment	?	If sent, Amount is expected
			04	Adjustment Quantity - Claim Level	s			Number of units over service being adjusted.	?	If sent, Quantity/Unit expected
			05	Adjustment Reason Code - Claim Level	s			Code identifying the detailed reason the adjustment was made.	?	Select valid applicable HIPAA code value
			06	Adjustment Amount - Claim Level	s			Amount of the Adjustment	?	If sent, Amount is expected
			07	Adjustment Quantity - Claim Level	s			Number of units over service being adjusted.	?	If sent, Quantity/Unit expected
			08	Adjustment Reason Code - Claim Level	s			Code identifying the detailed reason the adjustment was made.	?	Select valid applicable HIPAA code value
			09	Adjustment Amount - Claim Level	s			Amount of the Adjustment	?	If sent, Amount is expected
			10	Adjustment Quantity - Claim Level	s			Number of units over service being adjusted.	?	If sent, Quantity/Unit expected

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			11	Adjustment Reason Code - Claim Level	s			Code identifying the detailed reason the adjustment was made.	?	Select valid applicable HIPAA code value
			12	Adjustment Amount - Claim Level	s			Amount of the Adjustment	?	If sent, Amount is expected
			13	Adjustment Quantity - Claim Level	s			Number of units over service being adjusted.	?	If sent, Quantity/Unit expected
			14	Adjustment Reason Code - Claim Level	s			Code identifying the detailed reason the adjustment was made.	?	Select valid applicable HIPAA code value
			15	Adjustment Amount - Claim Level	s			Amount of the Adjustment	?	If sent, Amount is expected
			16	Adjustment Quantity - Claim Level	s			Number of units over service being adjusted.	?	If sent, Quantity/Unit expected
			17	Adjustment Reason Code - Claim Level	s			Code identifying the detailed reason the adjustment was made.	?	Select valid applicable HIPAA code value
			18	Adjustment Amount - Claim Level	s			Amount of the Adjustment	?	If sent, Amount is expected
			19	Adjustment Quantity - Claim Level	s			Number of units over service being adjusted.	?	If sent, Quantity/Unit expected
2320	332	AMT		COB Payer Paid Amount	s			Used primarily in payer-to-payer situations. Required if claim has been adjudicated by payer identified in this loop.	?	All AMT segments - Send if known
			01	Amount Qualifer Code	R			Code to qualify amount, use "D"	"D"	If sent, auto plug: "D"
			02	COB Payer Paid Amount	R			Amount paid by COB payer.	?	If sent, Amount is expected
2320	333	AMT		COB Approved Amount	s			Used primarily in payer-to-payer situations.	?	All AMT segments - Send if known
			01	Amount Qualifer Code	R			Code to qualify amount, use "AAE"	"AAE"	If sent, auto plug: "AAE"
			02	COB Approved Amount	R			Amount approved by COB payer.	?	If sent, Amount is expected
2320	334	AMT		COB Allowed Amount	s			Used primarily in payer-to-payer situations.	?	All AMT segments - Send if known
			01	Amount Qualifer Code	R			Code to qualify amount, use "B6"	"B6"	If sent, auto plug: "B6"
			02	COB Allowed Amount	R			Amount allowed by COB Payer.	?	If sent, Amount is expected
2320	335	AMT		COB Patient Responsibility Amount	s			Required if patient is resonsible for payment according to another payer's adjudication.	?	All AMT segments - Send if known
			01	Amount Qualifer Code	R			Code to qualify amount, use "F2"	"F2"	If sent, auto plug: "F2"
			02	Other Payer Patient Responsibility Amount	R			Other Payer Patient Responsibility Amount	?	If sent, Amount is expected
2320	336	AMT		COB Covered Amount	s			Used primarily in payer-to-payer situations.	?	All AMT segments - Send if known
			01	Amount Qualifer Code	R			Code to qualify amount, use "AU"	"AU"	If sent, auto plug: "AU"
			02	Other Payer Covered Amount	R			Other Payer Covered Amount	?	If sent, Amount is expected
2320	337	AMT		COB Discount Amount	s			Required if claim has been adjudicated by payer and if this information was included in the remittance advice reporting those adjudication results.	?	All AMT segments - Send if known
			01	Amount Qualifer Code	R			Code to qualify amount, use "D8"	"D8"	If sent, auto plug: "D8"
			02	Other Payer Discount Amount	R			Other Payer Discount Amount	?	If sent, Amount is expected
2320	338	AMT		COB Per Day Limit Amount	s			Required if claim has been adjudicated by payer and if this information was included in the remittance advice reporting those adjudication results.	?	All AMT segments - Send if known
			01	Amount Qualifer Code	R			Code to qualify amount, use "DY"	"DY"	If sent, auto plug: "DY"
			02	Other Payer Per Day Limit Amount	R			Other Payer Per Day Limit Amount	?	If sent, Amount is expected

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
2320	**339**	**AMT**		COB Patient Paid Amount	**s**			Required if claim has been adjudicated by payer and if this information was included in the remittance advice reporting those adjudication results.	**?**	**All AMT segments - Send if known**
			01	Amount Qualifer Code	**R**			Code to qualify amount, use "F5"	**"F5"**	**If sent, auto plug: "F5"**
			02	Other Payer Patient Paid Amount	**R**			Other Payer Patient Paid Amount	**?**	**If sent, Amount is expected**
2320	**340**	**AMT**		COB Tax Amount	**s**			Required if claim has been adjudicated by payer and if this information was included in the remittance advice reporting those adjudication results.	**?**	**All AMT segments - Send if known**
			01	Amount Qualifer Code	**R**			Code to qualify amount, use "T"	**"T"**	**If sent, auto plug: "T"**
			02	Other Payer Tax Amount	**R**			Other Payer Tax Amount	**?**	**If sent, Amount is expected**
2320	**341**	**AMT**		COB Total Claim Before Taxes Amount	**s**			Required if claim has been adjudicated by payer and if this information was included in the remittance advice reporting those adjudication results.	**?**	**All AMT segments - Send if known**
			01	Amount Qualifer Code	**R**			Code to qualify amount, use "T2"	**"T2"**	**If sent, auto plug: "T2"**
			02	Other Payer Total Claim Before Taxes Amount	**R**			Other Payer Total Claim Before Taxes Amount	**?**	**If sent, Amount is expected**
2320	**342**	**DMG**		Subscriber Demographic Info	**s**			Required when 2330A NM102 = 1 (person)		
			01	Date Time Period Qualifier	**R**			Code indicating the date format, use "D8"	**"D8"**	**If sent, auto plug: "D8"**
			02	Other Insured Date of Birth	**R**			Other Insured Date of Birth	**box 9b**	**If sent, expect Recipient Date of Birth**
			03	Other Insured Gender Code	**R**			Use: "F" for Female, "M" for Male, "U" for Unknown	**box 9b**	**If sent, expect appropriate HIPAA valid value**
2320	**344**	**OI**		Other Insurance Coverage Info	**R**	**R**		Info in the OI segment applies only to the payer in loop 230B of this iteration of the 2320 loop.	**?**	
			03	Other Insurance Assignment of Benefits Indicator	**R**	**R**		A "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N" value indicates benefits have not been assigned to the provider.	**?**	**AHCCCS Recipient would automatically have claim assigned. Expect value "Y" for Assignment of Benefits Indicator**
			04	Other Insurance Patient Signature Source Code	**s**			Code indicating how the patient or subscriber authorization signatures were obtained and how they are being retained by the provider. Refer to chart on page 345 in the TIG.	**?**	**Required when OI06 = "N". Select appropriate HIPAA valid value**
			06	Other Insurance Release of Information Code	**R**	**R**		Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations.		**Expect valid HIPAA value, if applicable. Since AHCCCS is a Title XIX Medicaid Program expect a "Y" since Assignment of Benefits and Release of Information are conditions of Medicaid enrollment.**
2320	**347**	**MOA**		Medicare Outpatient Adjudication Info	**s**			Required if returned in the electronic remittance advice, 835.	**-**	**This segment is not needed because Encounter will not use an 835 for Remittance Advicie**
2330A	**350**	**Other Subscriber Name**			**s**			Required for known other subscribers.	**-**	**Will expect at least one occurrence of this loop with Health Plan as Payer.**

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
2330A confusing usage in TIG	350	NM1		Other Subscriber Name	? R or S			Required for known other subscribers.	? Box 9a and 9	If this 2330A loop is within the MCO 2320 loop, this information would be that of the AHCCCS recipient. If there were other insurance involved, this would be the name of the person through whom the AHCCCS recipient has other insurance.
			01	Entity ID Code	R			Code identifying an entity or person, use: "IL" for Insured or Subscriber.	"IL"	Auto plug: "IL"
			02	Entity Type Qualifier	R			Qualifies Other Subscriber Name as person or entity. Use "1" for a Person, "2" for an entity.	? "1" - won't the other insured always be a person?	Select valid applicable HIPAA code value
			03	Other Insured (Subscriber) Last Name	R			Last name of subscriber for other insurance	box 9	Expect Other Subscriber's Last Name, when applicable
			04	Other Insured (Subscriber) First Name	s			First name of subscriber for other insurance	box 9	Expect Other Subscriber's First Name if NM102 = 1, when appplicable
			05	Other Insured (Subscriber) Middle Name	s			Middle name of subscriber for other insurance	box 9	Expect Other Subscriber's Middle Name if known and NM102 = 1, when applicable
			07	Other Insured (Subscriber) Name Suffix	s			Name Suffix of subscriber for other insurance	box 9	This element is not needed. Send if known.
			08	ID Code Qualifier	R			Code designating the system of the Member ID of the subscriber for the other insurance. Use: "MI" for Member ID Number, "ZZ" for Mutually Defied.		Select valid applicable HIPAA code value
			09	Other Insured Subscriber Primary ID	R			Other Insured Subscriber Primary ID	?	This will be either the AHCCCS ID for the recipient (in the MCP 2330A loop) or the ID of the Other Insured Subscriber
2330A	354	N3		Other Subscriber Address	s			required if available	?	This segment is not required. Will be ignored if sent.
			01	Other Insured Address Line 1	R			Other Insured Address Line 1	?	This element is not required.
			02	Other Insured Address Line 2	s			Other Insured Address Line 2	?	This element is not required.
2330A	355	N4		Other Subscriber City/State/Zip	s			required if available	?	This segment is not required. Will be ignored if sent.
			01	Other Insured City Name	R				?	This element is not required.
			02	Other Insured State Code	R				?	This element is not required.
			03	Other Insured Zip Code	R				?	This element is not required.
			04	Other Insured Country Code	s			Required if the address is out of the U.S.	?	This element is not required.
2330A	357	REF		Other Subscriber Secondary ID	s			Required if secondary identification is needed.	?	Send if known

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			01	Reference ID Qualifier	R			Code qualifying the Reference ID. Refer to chart on pages 357 358 in the TIG.	?	If sent, select appropriate HIPAA valid value
			02	Other Insured Additonal ID	R			Additional ID of subscriber of Other Insurance	?	Send if known
2330B		**Other Payer Name**			s			required if submitter knows of other payers	-	
2330B confusing usage in TIG	**359**	**NM1**		Other Payer Name	**? R or S**			required if submitter knows of other payers	box 9d & ?	
			01	Entity ID Code	R			Code identifying an entity or person as a payer, use "PR"	"PR"	Auto plug: "PR" in one occurrence. If others, expect appropriate HIPAA valid value
			02	Entity Type Qualifier	R			Code identifying the named party as an entity, use "2"	"2"	Auto plug: "2" if NM101 = PR. If others, expect appropriate HIPAA valid value
			03	Other Payer Organization Name	R			Other Payer Organization Name	box 9d ?	Send applicable Name of Other Payer. For the MCO 2330B loop, this will be the health plan name.
			08	ID Code Qualifier	R			Code designating the system of the Member ID of the subscriber for the other insurance. Use: "PI" for Payer ID, "XV" for HCFA national PlanID.	?	Select valid applicable HIPAA code value
			09	Other Payer Primary ID	R			Other Payer Primary ID	?	At least one occurrence will have Health Plan ID and TSN. Other occurrences will carry the ID Number for Other Payer(s).
2330B	**363**	**PER**		Other Payer Contact Info	s			only for payer-to-payer COB situations	?	This segment is Not Required - It will be ignored if sent.
			01	Contact Function Code	R			Use "IC" for Information Contact	"IC"	Not Needed
			02	Other Payer Contact Name	R				?	Not Needed
			03	Communication Number Qualifier	R			Code identifying the type of communication number. See chart on page 364.	?	Not Needed
			04	Communication Number	R				?	Not Needed
			05	Communication Number Qualifier	s			Code identifying the type of communication number. See chart on pages 364-365.	?	Not Needed
			06	Communication Number	s				?	Not Needed
			07	Communication Number Qualifier	s			Code identifying the type of communication number. See chart on pages 364-365.	?	Not Needed
			08	Communication Number	s				?	Not Needed
2330B	**366**	**DTP**		Claim Adjudication Date	s			Required when the payer identified in this iteration of loop 2330 has previously adjudicated the claim.	?	
			01	Date/Time Qualifier	R			Code specifying the type of date, use "573" to designate Date Claim Paid.	"573"	Not Needed
			02	Date Time Period Qualifier	R			Code specifying the date format at CCYYMMDD, use "D8"	"D8"	Not Needed
			03	Adjudication or Payment Date	R			Adjudication or Payment Date		Not Needed

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
2330B	368	REF		Other Payer Secondary ID	s			Required if secondary identification is needed.	?	
			01	Reference ID Qualifier	R			Code qualifying the Reference ID. Refer to chart on pages 368 369 in the TIG.	?	If sent, recommended code 'F8'
			02	Other Payer Secondary ID	R			Other Payer Secondary ID	?	AHCCCS encourages HP to use it to record HP's Claim Reference Number
2330B	370	REF		Other Payer Prior Authorization or Referral Number	s			Primarily used in payer-to-payer situations.	?	Not required unless used within MCO's 2330B loop to by-pass certain edits
			01	Reference ID Qualifier	R			Code qualifying the Reference ID. Refer to chart on page 370 in the TIG.	?	If sent, select appropriate HIPAA valid value
			02	Other Payer Prior Authorization or Referral Number				Other Payer Prior Authorization or Referral Number	?	If sent, expect Other Payer PA or Referral Number
2330B	372	REF		Other Payer Claim Adjustment Indicator	s			Required when the payer identified in this iteration of loop 2330 has previously adjudicated the claim and indicated so to the destination payer.	?	This segment is not needed and will be ignored if sent.
			01	Reference ID Qualifier	R			Code qualifying the Reference ID. Use "T4" to denote Signal Code.	"T4"	Not Needed
			02	Other Payer Claim Adjustment Indicator	R			Other Payer Claim Adjustment Indicator	?	Not Needed
2330C		**Other Payer Patient Info**			s			Use for non-destination payer COB situations	-	AHCCCS would not expect to receive this loop.
	374	NM1		Other Payer Patient Info	s					Not Needed
	376	REF		Other Payer ID	s					Not Needed
2330D		**Other Payer Referring Provider**			s				-	AHCCCS would not expect to receive this loop.
	378	NM1		Other Payer Referring Provider	s					Not Needed
	380	REF		Other Payer Referring Provider ID	R					Not Needed
2330E		**Other Payer Rendering Provider**			s				-	AHCCCS would not expect to receive this loop.
	382	NM1		Other Payer Rendering Provider	s					Not Needed
	384	REF		Other Payer Rendering Provider Secondary ID	R					Not Needed
2330F		**Other Payer Purchased Service Provi**			s				-	AHCCCS would not expect to receive this loop.
	386	NM1		Other Payer Purchased Service Provider	s					Not Needed
	388	REF		Other Payer Purchased Service Provider ID	R					Not Needed
2330G		**Other Payer Service Facility Location**			s				-	AHCCCS would not expect to receive this loop.
	390	NM1		Other Payer Service Facility Location	s					Not Needed
	392	REF		Other Payer Service Facility Location ID	R					Not Needed

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
2330H		**Other Payer Supervising Provider**			**s**				**-**	**AHCCCS would not expect to receive this loop.**
	394	**NM1**		Other Payer Supervising Provider	**s**					**Not Needed**
	396	**REF**		Other Payer Supervising Provider ID	**R**					**Not Needed**
2400		**Service Line**			**R**				**-**	
2400	**398**	**LX**		Service Line	**R**			The service line LX segment begins with 1 and is incrementd by one for each additional service line of a claim.		
			01	Line Counter	**R**			Line Counter	**? to the left of box 24 ?**	**Expect Health Plan line number**
2400	**400**	**SV1**		Professional Service	**R**			**For anesthesia, providers bill in 12 minute units while AHCCCS pays for 15 minute units. The claim processor calculates the number of units based on the beginning and ending time added to the claim below the anesthesia procedure code.**		
			01	Procedure ID				To identify a medical procedure by its standardized codes and applicable modifiers.		
			01-1	Product or Service ID Qualifier	**R**			Code identifying the type/source of the descriptive number used in Product/Servide ID. **Refer to chart on page 55 of the Addenda.**	**?**	**Expect valid HIPAA value in this field. Note: if qualifier N4 (NDC) used then new loop 2410 may be used to further define the service provided.**
			01-2	Procedure Code	**R**			Procedure Code	**box 24d**	**Expect Procedure Code**
			01-3	Procedure Modifier 1	**s**			Procedure Modifier 1. **Refer to chart on page 56 of the Addenda.**	**box 24d**	**Expect Procedure Modifier. AHCCCS will use this to price the claim.**
			01-4	Procedure Modifier 2	**s**			Procedure Modifier 2. **Refer to chart on page 56 of the Addenda.**	**box 24d**	**Expect Procedure Modifier. AHCCCS will use this to price the claim.**
			01-5	Procedure Modifier 3	**s**			Procedure Modifier 3. **Refer to chart on page 56 of the Addenda.**	**box 24d**	**Procedure Modifier. AHCCCS will accept and store, but not used in pricing**
			01-6	Procedure Modifier 4	**s**			Procedure Modifier 4. **Refer to chart on page 56 of the Addenda.**	**box 24d**	**Procedure Modifier. AHCCCS will accept and store, but not used in pricing**
			02	Line Item Charge Amount	**R**			Line Item Charge Amount	**box 24f**	**Expect Line Charge Amount**
			03	Unit or Basis for Measurement Code	**R**			Code specifying the units in which a value is expressed	**?**	**Select appropriate HIPAA valid value**
			04	Units or Minutes (Service Unit Count)	**R**			Units or Minutes (Service Unit Count). For anesthesia, providers bill in 12 minute units while AHCCCS pays for 15 minute units. The claim processor calculates the number of units based on the beginning and ending time added to the claim below the anesthesia procedure code.	**box 24g ?**	**Send applicable value. AHCCCS will be accept decimal values**

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			05	Place of Service Code	s			Required if the value is different from that in CLM-05-1 in loop 2300.	box 24b	Box 24b. Code "35" was not included in HIPAA IG. Brent suggested to use procedure codes. Need to further research to see if this is still an issue. Otherwise, use appropriate HIPAA code values.
			07	Diagnosis Code Pointer	s			Required if the HI segment in Loop 2300 is used.		
			07-1	Diagnosis Code Pointer to Primary Diagnosis	R			Diagnosis Code Pointer to Primary Diagnosis	box 24e	Expect Diagnosis Code Pointer for Primary Diagnosis Code. Box 24e
			07-2	Diagnosis Code Pointer 2	s			Diagnosis Code Pointer 2	box 24e	Expect Diagnosis Code Pointer from Box 24e
			07-3	Diagnosis Code Pointer 3	s			Diagnosis Code Pointer 3	box 24e	Expect Diagnosis Code Pointer from Box 24e
			07-4	Diagnosis Code Pointer 4	s			Diagnosis Code Pointer 4	box 24e	Expect Diagnosis Code Pointer from Box 24e
			09	Emergency Indicator	s			Emergency Indicator	box 24i	Send if known and applicable. Info could be frombox 24i
			11	EPSDT Indicator	s			EPSDT Indicator	box 24h ?	Send if known and applicable.
			12	Family Planning Indicator	s			Family Planning Indicator	box 24h ?	Send if known and applicable.
			15	Co-Pay Status Code	s			Required if patient was exempt from co-pay.	box 24j ?	Expect value "0" if applicable
deleted		SV4		Prescription Number					?	
2400 new segment		SV5		Durable Medical Equipment Service	s				?	This segment is required when reporting rental and purchase price information for durable medical equipment.
			01	Composite Medical Procedure ID	R			To identify a medical procedure by its standardized codes and applicable modifiers.	?	
			01-1	Procedure ID	R			Use "HC" for HCFA Common Procedural Coding System (HCPCS) Codes	?	If sent, expect value "HC"
			01-2	Procedure Code	R			This value must be the same as that reported in SV1-01-2.	?	If sent, the value must be as same as SV101-2
			02	Unit or Basis for Measurement Code	R			Code specifying the units in which a value is expressed. Use "DA" for Days.	"DA"	If sent, expect value "DA"
			03	Length of Medical Necessity	R			Numeric value or quantity.	?	Issue: Tina will check on the length of Time requirement
			04	DME Rental Price	s			Monetary amount.	?	If sent, expect the rental price of the equipment.
			05	DME Purchase Price	s			Monetary amount.	?	If sent, expect the purchase price of the equipment.
			06	Rental Unit Price Indicator	s			Code indicating frequency or type of payment. See pages 59-60 in the Addenda for values.	?	If sent, select the appropriate HIPAA values
2400	410	PWK		DMERC CMN Indicator	s			Required on Medicare claims when DMERC CMN is included.		AHCCCS does not participate in DMERC. Need further research.
			01	DMERC Report Type Code (Attachment Report Type Code)	R			Code of "CT" indicates Certification.	"CT"	Not Required

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			02	Attachment Transmission Code	R			Attachment Transmission Code - defines timing, transmission method or format by which reports are to be sent. Refer to chart on page 411 of the TIG.	?	Not Required
2400	412	CR1		Ambulance Transport Info	s			Required on all ambulance claims if the information is different than the CR1 at the claim level (Loop 2300).	?	
			01	Unit or Basis for Measurement Code	s			Required if CR1-02 is present. Use "LB" to signify Pound.	"LB"	If sent, auto plug: "LB"
			02	Patient Weight	s			Required if necessary to justify the medical necessity of the level of ambulance services.	?	Expect Patient Weight if applicable
			03	Ambulance Transport Code	R			Code indicating the type of ambulance transport. Use: "I" for Initial Trip, "R" for Return Trip, "T" for Transfer Trip, "X" for Round Trip.	?	Select appropriate HIPAA value if applicable
			04	Ambulance Transport Reason Code	R			Code indicating the reason for ambulance transport. Refer to the chart on pages 413-414 in the TIG.	?	Select appropriate HIPAA value if applicable
			05	Unit or Basis for Measurement Code	R			Use "DH" for miles.	"DH"	If sent, auto plug: "DH"
			06	Transport Distance	R			Distance (in miles) traveled during transport.	?	Expect Ambulance Miles in this field, if applicable.
			09	Round Trip Purpose Description	s			Purpose for the round trip ambulance service. Required if CR1 03 = "X" for Round Trip.	?	Expect reason for round trip ambulance, if applicable.
			10	Stretcher Purpose Description	s			Required if needed to justify usage of a stretcher.	?	Expect purpose for stretcher, if applicable.
2400	415	CR2		Spinal Manipulation Service Info	s			Required on all claims involving spinal manipulation if information is different from loop 2300 CR2. Only required if known to impact adjudication.	?	This segment is not required. Send if known and applicable.
			01	Treatment Series Number (Treatment Number - Spinal Manipulation)	n	n		Occurrence counter	?	Not used per Addenda
			02	Treatment Count (Treatment Series Total - Spinal Manipulation)	n	n		Total number of treatments in the series	?	Not used per Addenda
			03	Subluxation Level Code	n	n		Code identifying the specific level of subluxation. When both CR2-03 and CR2-04 are present, CR2-03 is the beginning level of subluxation and CR2-04 is the ending level of subluxation. Refer to the chart on pages 416-417 in the TIG.	?	Not used per Addenda
			04	Subluxation Level Code	n	n		Code identifying the specific level of subluxation. Required if additional subluxation is involved in claim to indicate a range. Refer to the chart on pages 417-418 in the TIG.	?	Not used per Addenda
			05	Unit or Basis for Measurement Code	n	n		Code specifying the units in which a value is being express. Refer to the chart on page 418 in the TIG.	?	Not used per Addenda
			06	Treatment Period Count (Treatment Serious Period - Spinal Manipulation)	n	n		Time period involved in the treatment series.	?	Not used per Addenda

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			07	Monthly Treatment Count (Treatment Number in Month, Spinal Manipulation)	n	n		Number of treatments rendered in the month of service.	?	Not used per Addenda
			08	Patient Condition Code - Spinal Manipulation	R			Code indicating the nature of a patient's condition. Refer to the chart on page 419 in the TIG.	?	Select appropriate HIPAA value if applicable
			09	Complication Indicator - Spinal Manipulation	n	n		A "Y" value indicates a complicated condition; an"N" value indicates an uncomplicated condition.	?	Not used per Addenda
			10	Patient Condition Description - Chiropractic	s			Description of Patient's Condition. Used at discretion of submitter.	?	Expect description of patient's condition in this field, if applicable.
			11	Patient Condition Description - Chiropractic	s			Description of Patient's Condition. Used at discretion of submitter.	?	Expect description of patient's condition in this field, if applicable.
			12	X-ray Availability Indicator Chiropractic	s			A "Y" value indicates X-rays are maintained and available for carrier review; an "N" value indicates X-rays are nt maintained and available for carrier review.	?	Select appropriate HIPAA value if applicable
2400	421	CR3		Durable Medical Equipment Certification	s			Required if necessary to include supporting documentation in an electronic form for Medicare DMERC claims for which the provider is required to obtain a certificate of medical necessity (CMN) from the physician.	?	This segment is not needed and not required. Send if known and applicable.
			01	Certification Type Code	R			Code indicating the type of certification. Refer to page 421 of the TIG.	?	If sent, select appropriate HIPAA value if applicable
			02	Unit or Basis for Measurement Code	R			Use "MO" for Months.	"MO"	If sent, expect value "MO"
			03	DME Duration	R			Length of time DME equipment is needed	?	If sent, expect the duration of DME
2400	423	CR5		Home Oxygen Therapy Info	s			Required on all home oxygen therapy claims.	?	
			01	Certification Type Code - Oxygen Therapy	R			Code indicating the type of certificaiton. Refer to chart on page 424 of the TIG.	?	If sent, select appropriate HIPAA value if applicable
			02	Certification Period - Home Oxygen Therapy	R			Number of months covered by certification	?	If sent, expect Treatment Period count
			10	Arterial Blood Gas	s			Required on claims which report artreial blood gas; either CR5-10 or CR5-11 is required.	?	If sent, expect Arterial Blood Gas Quantity
			11	Oxygen Saturation	s			Required on claims which report artreial blood gas; either CR5-10 or CR5-11 is required.	?	If sent, expect Oxygen Saturation Quantity
			12	Oxygen test condition code	R			Code indicating the conditions under which a patient was tested. See chart on page 425 of the TIG.	?	If sent, select appropriate HIPAA value if applicable
			13	Oxygen Test Finding code	s			Required if patient's arterial PO2 is greater than 55 mmHG and less than 60mmHg or oxygen saturation is greater than 88%. See chart on page 425 of the TIG.	?	If sent, auto plug: "1"
			14	Oxygen Test Finding code	s			Required if patient's arterial PO2 is greater than 55 mmHG and less than 60mmHg or oxygen saturation is greater than 88%. See chart on page 425 of the TIG.	?	If sent, auto plug: "2"
			15	Oxygen Test Finding code	s			Required if patient's arterial PO2 is greater than 55 mmHG and less than 60mmHg or oxygen saturation is greater than 88%. See chart on page 425 of the TIG.	?	If sent, auto plug: "3"
2400	427	CRC		Ambulance Certification	s			Required on all service lines which bill/report ambulance services if the information is different when CRC01-07 in loop 2300.	?	

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			01	Code Category	R			Code Category, use "07" for Ambulance Certification.	"07"	If sent, auto plug: "07"
			02	Certification Condition Code Applies Indicator	R			Certification Condition Code Applies Indicator. A "Y" value indicates that the condition codes in CRC03 through CRC-07 apply; an "N" value indicates the condition codes in CRC-03 through CRC-07 do not apply.	?	If sent, select appropriate HIPAA value if applicable
			03	Condition Code	R			Condition Code, refer to pages 428-429 in the TIG.	?	If sent, select appropriate HIPAA value if applicable
			04	Condition Code	s			Condition Code, refer to pages 428-429 in the TIG.	?	If sent, select appropriate HIPAA value if applicable
			05	Condition Code	s			Condition Code, refer to pages 428-429 in the TIG.	?	If sent, select appropriate HIPAA value if applicable
			06	Condition Code	s			Condition Code, refer to pages 428-429 in the TIG.	?	If sent, select appropriate HIPAA value if applicable
			07	Condition Code	s			Condition Code, refer to pages 428-429 in the TIG.	?	If sent, select appropriate HIPAA value if applicable
2400	430	CRC		Hospice Employee Indicator	s			Required on all Medicare claims involving physician services to hospice patients.	?	
			01	Code Category	R			Code specifying the situation, use "70" for hospice.	"70"	If sent, expect value "70"
			02	Hospice Employee Indicator	R			A "Y" value indicates the condition codes in CRC-03 through CRC-07 apply; an "N" value indicates the condition codes in CRC-03 through CRC-07 do not apply.	?	If sent, expect appropriate HIPAA valid value of "Y" or "N"
			03	Condition Indicator	R			Use "65" as a place holder (element is mandatory) when reporting whether the provider is a hospice employee.	?	If sent, expect value "65". This code is a place holder when reporting whether the provider is a hospice employee.
2400	432	CRC		DMERC Condition Indicator	s			Required on all oxygen therapy and DME claims that require a certificate of medical necessity (CMN).	?	This segment is not required.
			01	Code Category	R			Specifies the situation as either DME or Oxygen Therapy certification. Use "09" for DME, "11" for Oxygen Therapy.	?	Not needed
			02	Certification Condition Code Applies Indicator	R			A "Y" value indicates the condition codes in CRC-03 through CRC-07 apply; an "N" value indicates the condition codes in CRC-03 through CRC-07 do not apply.	?	Not needed
			03	Condition Indicator	R			Refer to chart on page 433-434 of the TIG for patient conditions.	?	Not needed
			04	Condition Indicator	R			Refer to chart on page 433-434 of the TIG for patient conditions.	?	Not needed
			05	Condition Indicator	R			Refer to chart on page 433-434 of the TIG for patient conditions.	?	Not needed
			06	Condition Indicator	R			Refer to chart on page 433-434 of the TIG for patient conditions.	?	Not needed
			07	Condition Indicator	R			Refer to chart on page 433-434 of the TIG for patient conditions.	?	Not needed
2400	435	DTP		Date - Service Date	R			For drugs billed on a service line, the Date of Service may be used to indicate the range of dates through which the drug will be used by the patient. For drugs billed on a service line, the Date of Service DTP is used to indicate the date the prescription was written. Required if DMERC Certification (CR3-01) = "R" or "S"	box 24a or ?	

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			01	Date Time Qualifier	R			Use "472" to denote Service Date.	"472"	Auto plug: "472"
			02	Date Time Period Format Qualifier	R			Code indicating the date format. Refer to chart on page 436 in the TIG.	box 24a or ?	Select appropriate HIPAA value.
			03	Service Date(s)	R			Drug Usage / Prescription Dates	box 24a or ?	Info could be from box 24a, or appropriate value
2400	437	DTP		Date - Certification Revision Date	s			Required if CR3-01 (DMERC certification) is "R" or "S".	?	This segment is not needed and not required. Send if known and applicable.
			01	Date Time Qualifier	R			Use "607" to denote Certification Revision	"607"	If sent, expect value "607"
			02	Date Time Period Format Qualifier	R			Use "D8" to denote CCYYMMDD date format.	"D8"	If sent, expect value "D8"
			03	Date - Certification Revision Date	R			Certification Revision Date	?	Expect applicable date
deleted	439	DTP		Date - Referral Date	s			Required if the service line includes a referral.	?	This segment: Referral Date was deleted from Addenda
2400	440	DTP		Date - Begin Therapy Date	s			Required if it is necessary to include suporting documentation in an electronic form for Medicare DMERC claims for which the provider iks required to obtain a certificate of medical necessity (CMN) from the physician.	?	This segment is not required. Send if known and applicable.
			01	Date Time Qualifier	R			Use "463" to denote Begin Therapy	"463"	If sent, expect value "463"
			02	Date Time Period Format Qualifier	R			Use "D8" to denote CCYYMMDD date format.	"D8"	If sent, expect value "D8"
			03	Begin Therapy Date	R			Begin Therapy Date	?	Expect applicable date
2400	442	DTP		Date - Last Certification Date	s			Required if it is necessary to include suporting documentation in an electronic form for Medicare DMERC claims for which the provider iks required to obtain a certificate of medical necessity (CMN) from the physician. Required on oxygen therapy certificates of medical necessity (CMN).	?	This segment is not required. Send if known and applicable.
			01	Date Time Qualifier	R			Use "481" to denote Last Certification	"481"	If sent, expect value "481"
			02	Date Time Period Format Qualifier	R			Use "D8" to denote CCYYMMDD date format.	"D8"	If sent, expect value "D8"
			03	Last Certification Date	R			Last Certification Date	?	Expect applicable date
deleted	444	DTP		Date - Order Date	s			Required when service line includes an order for services or supplies.	?	This segment was deleted by Addenda
2400	445	DTP		Date - Date Last Seen	s			Required when claim is from an independent physical therapist, occupational therapist or physican providing routine footcare if the date last seen by an attending or supervising physician is different from that listed at the claim level (loop 2300). **Only required if known to impact the adjudication process.**	?	Send if known and applicable.
			01	Date Time Qualifier	R			Use "304" to denote Latest Visit or consulation	"304"	If sent, expect value "304"
			02	Date Time Period Format Qualifier	R			Use "D8" to denote CCYYMMDD date format.	"D8"	If sent, expect value "D8"
			03	Date Last Seen	R			Date Last Seen	?	Expect applicable date
2400	447	DTP		Date - Test	s			Required on initial EPO claim service lines where test results are being billed/reported.	?	Send if known and applicable.
			01	Date Time Qualifier	R			Use: "738" for Most Recent Hemoglobin or Hematocrit or Both, "739" for Most Recent Serum Creatine.	?	If sent, select appropriate HIPAA code values

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			02	Date Time Period Format Qualifier	R			Use "D8" to denote CCYYMMDD date format.	"D8"	If sent, expect value "D8"
			03	Test Performed Date	R			Test Performed Date	?	Expect applicable date
2400	449	DTP		Date - Oxygen Saturation/Arterial Blood Gas Test	s			Required on initial oxygen therapy servicelines involving certificate of medical necessity (CMN).	?	Send if known and applicable.
			01	Date Time Qualifier	R			Refer to chart on pages 449-450 in the TIG.	?	If sent, select appropriate HIPAA code values
			02	Date Time Period Format Qualifier	R			Use "D8" to denote CCYYMMDD date format.	"D8"	If sent, expect value "D8"
			03	Oxygen Saturation Test Date	R			Oxygen Saturation Test Date	?	Expect applicable date
2400	451	DTP		Date - Shipped	s			Required when billing/reporting shipped products.	?	Send if known and applicable.
			01	Date Time Qualifier	R			Use "011" to denote Date Shipped	"011"	If sent, expect value "011"
			02	Date Time Period Format Qualifier	R			Use "D8" to denote CCYYMMDD date format.	"D8"	If sent, expect value "D8"
			03	Date Shipped	R			Date Shipped	?	Expect applicable date
2400	452	DTP		Date - Onset of Current Symptom/Illness	s			Required if different from that entered at claim level loop 2300.	?	Send if known and applicable.
			01	Date Time Qualifier	R			Use "431" to denote Onset date	"431"	If sent, expect value "431"
			02	Date Time Period Format Qualifier	R			Use "D8" to denote CCYYMMDD date format.	"D8"	If sent, expect value "D8"
			03	Onset Date	R			Onset Date	?	Expect applicable date
2400	454	DTP		Date - Last X-ray	s			Required for spinal manipulation certifications if different than information at claim level (loop 2300).	?	Send if known and applicable.
			01	Date Time Qualifier	R			Use "455" to denote Last X-Ray	"455"	If sent, expect value "455"
			02	Date Time Period Format Qualifier	R			Use "D8" to denote CCYYMMDD date format.	"D8"	If sent, expect value "D8"
			03	Last X-ray Date	R			Last X-ray Date	?	Expect applicable date
2400	456	DTP		Date - Acute Manifestation	s			Required for spinal manipulation certifications if different than information at claim level (loop 2300).	?	Send if known and applicable.
			01	Date Time Qualifier	R			Use "453" to denote Acute Manifestation	"453"	If sent, expect value "453"
			02	Date Time Period Format Qualifier	R			Use "D8" to denote CCYYMMDD date format.	"D8"	If sent, expect value "D8"
			03	Acute Manifestation Date - Spinal Manipulation	R			Acute Manifestation Date - Spinal Manipulation	?	Expect applicable date
2400	458	DTP		Date - Initial Treatment	s			Required for spinal manipulation for Medicare Part B if different than information at claim level (loop 2300).	?	This segment is not required. Send if known and applicable.
			01	Date Time Qualifier	R			Use "454" to denote Initial Treatment	"454"	If sent, expect value "454"
			02	Date Time Period Format Qualifier	R			Use "D8" to denote CCYYMMDD date format.	"D8"	If sent, expect value "D8"
			03	Initital Treatment Date - Spinal Manipulation	R			Initital Treatment Date - Spinal Manipulation	?	Expect applicable date
2400	460	DTP		Date - Similar Illness Symptom Onset	s			Required if line value is different than value given at claim level (loop 2300) and claim involves services to a patient experiencing problems symptoms similar or identical to previously reported symptoms.	?	Send if known and applicable.
			01	Date Time Qualifier	R			Use "438" to denote Similar Illness/Symptom Onset	"438"	If sent, expect value "438"
			02	Date Time Period Format Qualifier	R			Use "D8" to denote CCYYMMDD date format.	"D8"	If sent, expect value "D8"

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			03	Similar Illness or Symptom Date	R			Similar Illness or Symptom Date	?	Expect applicable date
deleted	462	QTY		Anesthesia Modifying Units	s			Required on anesthesia service lines if one or more of the extenuating circumstances coded in QTY01 was present a the time of service.	?	This segment is deleted by Addenda
2400	464	MEA		Test Result	s			See addenda page 66 for required usage.	?	This segment is sent if it is applicable to the Encounter
			01	Mesurement Reference ID Code	R			Measurement ID	?	If sent, select appropriate HIPAA code values
			02	Measurement Qualifier	R			Code specifying the type of quantity. Refer to chart on page 67 in the Addenda.	?	If sent, select appropriate HIPAA code values
			03	Test Results	R			See addenda page 67 for description of test results.	?	If sent, expect appropriate value
2400	466	CN1		Contract Info	s			Information at this level overwrites CN1 info at the claim level for the specific service line.	?	
			01	Contract Type Code	R			Code identifying a contract type. Refer to chart on page 466 of the TIG	?	Expect the Sub Cap Code in this element, if appropriate. Use appropriate HIPAA value
			02	Contract Amount	s			Required if information is different than that given at the claim level	?	If sent, expect appropriate value
			03	Contract Percentage	s			Required if information is different than that given at the claim level	?	If sent, expect appropriate value
			04	Contract Code	s			Required if information is different than that given at the claim level	?	If sent, expect appropriate value
			05	Terms Discount Percentage	s			Required if information is different than that given at the claim level	?	If sent, expect appropriate value
			06	Contract Version ID	s			Required if information is different than that given at the claim level	?	If sent, expect appropriate value
2400	468	REF		Repriced Line Item Reference Number	s			This segment is intended to be used exclusively by repricing (pricing organizations who have a need to identify a certain line in their claim submission transmission to their payer organization.		This segment is not required.
2400	469	REF		Adjusted Repriced Line Item Reference Number	s			This segment is intended to be used exclusively by repricing (pricing organizations who have a need to identify a certain line in their claim submission transmission to their payer organization.		This segment is not required.
2400	470	REF		Prior Authorization or Referral Number	s			Required if service line involved a prior auth that is different than the number reported at the claim level.	?	This segment can be sent if known and applicable.
			01	Reference ID qualifier	R			Code qualifying the Reference ID. Refer to page 470 in the TIG.	?	If sent, select appropriate HIPAA valid values
			02	Prior Authorization or Referral Number	R			Prior Authorization or Referral Number	?	If sent, expect appropriate value
2400	472	REF		Line Item Control Number	s			Required if it is necessary to send a line control or inventory number. Providers are strongly encouraged to routinely send a unique line item control number on all service lines.		
			01	Reference ID qualifier	R			Code qualifying the Reference ID. Refer to page 470 in the TIG.	?	If sent, auto plug: "6R"

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			02	Line Item control Number	R			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	?	If sent, expect Line Item Control Number
2400	474	REF		Mammography Certification Number	s			Required for mammography services rendered by a certified mammography provider.	?	This segment can be sent if known and applicable.
			01	Reference ID qualifier	R			Code qualifying the Reference ID. Use "EW" to denote Mammography Certification Number.	"EW"	If sent, auto plug: "EW"
			02	Mammography Certification Number	R			Mammography Certification Number	?	If sent, expect appropriate value.
2400	475	REF		Clinical Laboratory Improvement Amendment ID	s			Required for all CLIA certified facilities performing CLIA covered laboratory services and if number is different than CLIA number reported at claim level loop 2300.	?	This segment can be sent if known and applicable.
			01	Reference ID qualifier	R			Use "X4" for CLIA Number	"X4"	If sent, auto plug: "X4"
			02	Clinical Laboratory Improvement Amendment ID	R			Clinical Laboratory Improvement Amendment ID	?	If sent, expect appropriate value. CLIA Number can be derived.
2400	477	REF		Referring Clinical Laboratory Improvement Amendment Facility ID	s			Required for Medicare claims for any laboratory that referred test to another laboratory covered by the CLIA Act that is billed on thi line.	?	This segment is not required. Send if known and applicable.
			01	Reference ID qualifier	R			Use "F4" for Facility Certification Number	"F4"	If sent, auto plug: "F4"
			02	Referring Clinical Laboratory Improvement Amendment Facility ID	R			Referring Clinical Laboratory Improvement Amendment Facility ID	?	If sent, expect appropriate value.
2400	478	REF		Immunization Batch Number	s			Use when required by state law for health data reporting.	?	This segment is not required. Send if known and applicable.
			01	Reference ID qualifier	R			Use "BT" for Batch Number		If sent, auto plug: "BT"
			02	Immunization Batch Number	R			Immunization Batch Number	?	If sent, expect appropriate value.
2400	479	REF		Ambulatory Patient Group	s			Used at the discretion of submitter.	?	
			01	Reference ID qualifier	R			Use "1S" for Batch Number		If sent, auto plug: "1S"
			02	Ambulatory Patient Group Number	R			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	?	If sent, expect appropriate value.
2400	480	REF		Oxygen Flow Rate	s			Required on oxygen therapy certificate of medical necessity (CMN) claim where srvice line reports oxygen flow rate.	?	This segment is not required. Send if known and applicable.
			01	Reference ID qualifier	R			Use "TP" for Test Specifiation Number (Oxygen Flow Rage)	"TP"	If sent, auto plug: "TP"
			02	Oxygen Flow Rate	R			Oxygen Flow Rate	?	If sent, expect appropriate value.
2400	482	REF		Universal Product Number	s			X12N has been informed by HCFA that **this information will be required on Medicare claims in the near future.**	?	This segment is not needed at this time.
			01	Reference ID qualifier	R			Code qualifying the Reference ID. Refer to chart on page 483 of the TIG.	?	Not needed
			02	Universal Product Number	R			Universal Product Number	?	Not needed

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
2400	484	AMT		Sales Tax Amount	s			Required if sales tax applies to service line and submitter is required to report that information to the receiver.	?	This segment is not needed at this time.
			01	Amount Qualifier Code	R			Use "T" for Tax	"T"	If sent, auto plug: "T"
			02	Sales Tax Amount	R			Sales Tax Amount	?	If sent, expect appropriate amount.
2400	485	AMT		Approved Amount	s			Used primarily in payer-to-payer COB situations by the payer who is sending this claim to another payer.	?	This segment is not required. Send if known and applicable
			01	Amount Qualifier Code	R			Use "AAE" for Approved Amount	"AAE"	If sent, auto plug: "AAE"
			02	Approved Amount	R			Approved Amount		If sent, expect appropriate amount.
2400	486	AMT		Postage Claimed Amount	s			Required if service line charge (SV102) includes postage amount claimed in this service line.	?	This segment is not required. Send if known and applicable
			01	Amount Qualifier Code	R			Use "F4" for Postage Claimed	"F4"	If sent, auto plug: "F4"
			02	Postage Claimed Amount	R			Postage Claimed Amount	?	If sent, expect appropriate amount.
2400	487	K3		File Info	s	n	n	May only be used to meet an emergency legislative requirement with prior review of the X12N workgroup.		Not needed at this time
2400	488	NTE		Line Note	s			Required if submitter used a "not otherwise classified" procedure code on this service line. Otherwise, use at provider's discretion.	?	Not needed at this time
			01	Note Reference Code	R			Code identifying the functiona area or purpose for which thenote applies. Refer to chart on page 488 in the TIG.	?	Not needed
			02	Line Note Text	R			Line Note Text	?	Not needed
2400	489	PS1		Purchased Service Info	s			**Refer to page 69 of addenda for required usage and other information.**	?	This segment is not required. Send if known and applicable.
			01	Reference ID (Purchased Service provider ID)	R			Provider ID Number	?	If sent, expect AHCCCS Provider ID and Service Locator Code
			02	Purchased Service Charge Amount	R			Purchased Service Charge Amount		If sent, expect Purchase Service Charge Amount.
2400	491	HSD		Healthcare Services Delivery	s			Required on claims billing/reporting home health visits where further detail is necessary to clearly substantiate medical treatment and if information is different than that given at claim level inloop 2300.	?	
			01	Visits	s			Use "VS" for Visits. Required if information is different than that given at the claim level.	"VS"	If sent, auto plug: "VS"
			02	Number of Visits	s			Number of visits. Required if information is different than that given at the claim level.	?	If sent, expect number of visits
			03	Frequency Period	s			Frequency Period. Refer to chart on pages 492-493 in the TIG. Required if information is different than that given at the claim level.	?	If sent, select appropriate HIPAA valid values
			04	Frequency Count	s			Required if information is different than that given at the claim level.	?	If sent, expect sampling frequency in terms of a modulus of the Unit of Measure
			05	Duration of Visit Units	s			Duration of Visits. Required if information is different than that given at the claim level	?	If sent, select appropriate HIPAA valid values
			06	Duration of Visits, Number of Units	s			Required if information is different than that given at the claim level	?	If sent, expect Duration of Visits, or Number of Visits.
			07	Pattern of Visits Code	s			Required if information is different than that given at the claim level Refer to chart on pages 493-494 in the TIG.	?	If sent, select appropriate HIPAA valid values

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			08	Delivery Pattern Time Code	s			Required if information is different than that given at the claim level	?	If sent, select appropriate HIPAA valid values
2400	495	HCP		Line Pricing/repricing Info	s			Used only by repricers as needed. This information is specific to the destination payer reported in loop 2010BB.		Not Required
2410	addenda	new loop		**Drug Identification**	s					
2410 new segment		LIN		Drug Identifiation	s			Required when NDC usage in necessary to further define the service.		This segment is not required. Send if known and applicable
			02	Product/Service ID Qualifier	R			Use "N4" for National Drug Code in a 5-4-2 format	"N4"	If sent, auto plug: "N4"
			03	National Drug Code	R			Identifying number of product or service	?	If sent, expect valid National Drug Code
2410 new segment		CTP		Drug Pricing	s			Required when it is necessary to provide a price specific to the NDC provided in LIN-03.		This segment is not required. Send if known and applicable
			03	Drug Unit Price	R				?	If sent, expect valid Drug Unit Price
			04	National Drug Unit Count	R				?	If sent, expect National Drug Unit Count
			05	Unit / Basis of Measurement	R			Composite field	?	
			05-1	Code qualifier	R			Refer to chart on page 74 in the addenda.	?	If sent, select appropriate HIPAA valid value
2410 new segment		REF		Prescription Number	s			Required if dispensing of the drug has been done with an assigned Rx number. In cases where a compound drug is being billed, the components will all have the same prescription number.		This segment is not required. Send if known and applicable
			01	Code qualifier	R			Use "XZ" to denote pharmacy prescription number.	"XZ"	If sent, auto plug: "XZ"
			02	Prescription Number	R				?	If sent, expect valid Prescription Number
2420A		**Rendering Provider Name**			s				-	Loop 2420A can be sent if different than Claim Level. Refer to Claim level for mapping detail
2420A	501	NM1		Rendering Provider Name	s					This segment is not required unless the information is different with the Claim Level Rendering Provider
			01	Entity ID Code	R			Use "82" to specify Rendering Provider	"82"	If sent, auto plug: "82"
			02	Entity Type Qualifier	R			Use: "1" for Person, "2" for entity.	?	If sent, select appropriate HIPAA valid value
			03	Rendering Provider Last Name or Organization Name	R			Rendering Provider Last Name or Organization Name	?	If sent, expect Name applicable with NM102
			04	Rendering Provider First Name	s			Rendering Provider First Name	?	Only send if NM102 = 1, and Rendering Provider First Name is known.
			05	Rendering Provider Middle Name	s			Rendering Provider Middle Name	?	Only send if NM102 = 1, and Rendering Provider Middle Name is known.
			07	Rendering Provider Name Suffix	s			Rendering Provider Name Suffix	?	This element is not needed

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			08	ID Code Qualifier	R			Code designating the system used for the ID. Refer to chart on page 503 of TIG.	?	If sent, select appropriate HIPAA valid value
			09	Rendering Provider Primary ID	R			Primary ID for Rendering Provider of Service Line	?	If sent, expect Employer ID or SSN, whichever is applicable.
2420A usage changed to 'S'	504	PRV		Rendering Provider Specialty Info	s	n	n	Required when adjudication is known to be impacted by provider taxonomy code.		This segment is not required.
			01	Provider Code	R			Use "PE" to indicate Performing	"PE"	Not needed
			02	Reference ID qualifier	R			Use "ZZ" to indicate Mutually Defined Health Care Provider Taxonomy Code List	"ZZ"	Not needed
			03	Provider Specialty Code	R				?	Not needed
2420A	507	REF		Rendering Provider Secondary ID	s			Required if secondary identification is needed.	?	
			01	Reference ID qualifier	R			Code qualifyig the Reference ID. Refer to chart on pages 507-508 in the TIG.	?	If sent, select appropriate HIPAA valid value
			02	Rendering Provider Secondary ID	R			Rendering Provider Secondary ID	?	If sent, expect AHCCCS Provider ID and Service Locator Code
2420B		**Purchased Service Provider Name**			s				-	Loop 2420B can be sent if different than Claim Level.
2420B	509	NM1		Purchased Service Provider Name	s			Required if purchased services are being billed/reported on this claim.		
			01	Entity ID Code	R			Use "QB" for Purchase Service Provider	"QB"	If sent, auto plug: "QB"
			02	Entity Type Qualifier	R			Code qualifyig the entity. Use: "1" for Person, "2" for Entity.		If sent, select appropriate HIPAA valid value
			08	ID Code Qualifier	s			Code designating the system/method of code structure. Required if either the EIN, SSN or National Provider's ID is known. Refer to chart on page 510 of the TIG.	?	If sent, select appropriate HIPAA valid value
			09	Purchased Service Provider's Primary ID Number	s			Required if either EIN/SN or National Provider ID is known	?	If sent, expect Employer ID or SSN, whichever is applicable.
2420B	512	REF		Purchased Service Provider Secondary ID	s			Required if secondary identification is needed.		This segment is not required unless the information is different with the Claim Level.
			01	Reference ID qualifier	R			Code qualifying the reference ID. See chart on pages 512-513 of the TIG.	?	If sent, auto plug: "1D"
			02	Reference ID	R			Purchased Service Provider Secondary ID	?	If sent, expect AHCCCS Provider ID and Service Locator Code
2420C		**Service Facility Location**			s				-	Loop 2420C is not needed. Send if information is different than Claim level.
2420C	514	NM1		Service Facility Location	s			Required when the location of health care service for this service line is different than that carried in the 2010AA Billing Provider, 2010AB Pay-to Provider or 2310D Service Facility Location loops.		
			01	Entity ID Code	R			Code identifying an entity, location, property or person. Refer to page 515 of the TIG.	?	If sent, select appropriate HIPAA valid value
			02	Entity Type Qualifier	R			Use "2" for facility	"2"	If sent, auto plug: "2"

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			03	Lab or Facility Name - Service Facility Location Name	s			Required except when service was rendered in the patient's home.	?	If sent, expect Name applicable with NM102
			08	ID Code Qualifier	s			Code designating the system/method of code structure. Required if either the EIN, SSN or National Provider's ID is known. Refer to chart on pages 515-516 of the TIG.	?	If sent, select appropriate HIPAA valid value
			09	Laboratory or Facility Primary ID - Service Facility Locatin ID Number	s			Required if the EIN/SSN or Nationa Provider ID is known.	?	If sent, expect Employer ID or SSN, whichever is applicable.
2420C	518	N3		Service Facility Location Address	? R or s ?			usage is questionable - is the address for the service facility needed for each service line a claim?		This segment is not required. Send if known and applicable
			01	Service Facility Location Address 1	R			Address of service facility	?	If sent, expect valid address of Service Facility
			02	Service Facility Location Address 2	s			Address of service facility	?	This element is not needed
2420C	519	N4		Service Facility Location City/State/Zip	? R or s ?			usage is questionable - is the address for the service facility needed for each service line a claim?	?	This segment is not required. Send if known and applicable
			01	Service Facility Location City	R			Address of service facility	?	If sent, expect valid City Name of Service Facility
			02	Service Facility Location State	R			Address of service facility	?	If sent, expect valid State Code of Service Facility
			03	Service Facility Location Zip	R			Address of service facility	?	If sent, expect valid Zip Code of Service Facility
			04	Service Facility Location Country Code	s			Address of service facility	?	This element is not needed
2420C	521	REF		Service Facility Location Secondary ID	s			Required if secondary identification is needed.	?	This segment is not required unless the information is different with the Claim Level.
			01	Reference ID qualifier	R			Code qualifying the Reference ID. Refer to pages 521-522 of the TIG.	?	If sent, auto plug: "1D"
			02	Service Facility Location Secondary ID Number	R			Service Facility Location Secondary ID Number	?	If sent, expect AHCCCS Provider ID and Service Locator Code
2420D		**Supervising Provider Name**			s				-	Loop 2420D is not needed. Send if information is different than Claim level.
2420D	523	NM1		Supervising Provider Name	s			Required when rendering provider is supervised by aphysician and the supervising physician is different than that listed at the claim level for this service line.	?	
			01	Entity ID Code	R			Code identifying an entity, location, property or person. Use "DQ" for supervising physician.	"DQ"	If sent, auto plug: "DQ"
			02	Entity Type Qualifier	R			Use "1" for Person.	"1"	If sent, auto plug: "1"
			03	Supervising Provider Last Name	R			Last name of supervising provider.	?	If sent, expect Supervising Provider Last Name
			04	Supervising Provider First Name	R			First name of supervising provider.	?	If sent, expect Supervising Provider First Name.

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			05	Supervising Provider Middle Name	s			Middle name of supervising provider.	?	if sent, expect Supervising Provider Middle Name
			07	Supervising Provider Name Suffix				Name suffix of supervising provider.	?	This element is not needed
			08	ID Code Qualifier	s			Code designating the syste of code used for ID code. Refer to chart on page 525 of the TIG.	?	If sent, select appropriate HIPAA valid value
			09	Supervising Provider's ID Number	s			Supervising Provider's ID Number	?	If sent, expect Supervising Provider SSN or EIN
2420D	527	REF		Supervising Provider Secondary ID	s			Required if secondary identification is needed.		This segment is not required unless the information is different with the Claim Level.
			01	Reference ID qualifier	R			Code qualifying the Reference ID. Refer to pages 527-528 of the TIG.	?	If sent, auto plug: "1D"
			02	Supervising Provider Secondary ID	R			Supervising Provider Secondary ID	?	If sent, expect AHCCCS Provider ID and Service Locator Code
2420E		**Ordering Provider Name**			s				-	Loop 2420E is not needed. Send if information is different than Claim level.
2420E	529	NM1		Ordering Provider Name	s			Required if a service or supply was ordered by a provider ant that provider is a different entity than the rendering provider for this service line.		
			01	Entity ID Code	R			Use "DK" for Ordering Physician.	"DK"	If sent, auto plug: "DK"
			02	Entity Type Qualifier	R			Use "1" for Person.	"1"	If sent, auto plug: "1"
			03	Ordering provider last name	R			Ordering provider last name	?	If sent, expect Ordering Provider Last Name
			04	Ordering provider first name	R			Ordering provider first name	?	If sent, expect Ordering Provider First Name.
			05	Ordering provider middle name	s			Ordering provider middle name	?	if sent, expect Ordering Provider Middle Name
			07	Ordering provider name suffix	s			Ordering provider name suffix	?	This element is not needed
			08	ID Code Qualifier	s			Required if EIN/SSN or National Provider ID is known.	?	If sent, select appropriate HIPAA valid value
			09	Ordering Provider Primary ID				Ordering Provider Primary ID	?	If sent, expect Ordering Provider SSN or EIN
2420E	533	N3		Ordering Provider Address	s			Required when a Durable Medical Equipment Regional Carrier Certificate of Medical Necessity (Medicare DMERC CMN) is used on service line for Medicare claims.		This segment is not required. Send if known and applicable
			01	Ordering Provider Address Line 1	R			Ordering Provider Address Line 1	?	If sent, expect Ordering Provider Street address
			02	Ordering Provider Address Line 2	s			Ordering Provider Address Line 2	?	This element is not needed
2420E	534	N4		Ordering Provider City/State/Zip	s			Required when a Durable Medical Equipment Regional Carrier Certificate of Medical Necessity (Medicare DMERC CMN) is used on service line for Medicare claims.		This segment is not required. Send if known and applicable
			01	Ordering Provider City	R			Ordering Provider City	?	If sent, expect Ordering Provider City Name
			02	Ordering Provider State	R			Ordering Provider State	?	If sent, expect Ordering Provider State Code

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			03	Ordering Provider Zip Code	R			Ordering Provider Zip Code	?	If sent, expect Ordering Provider Zip Code
			04	Ordering Provider Country code				Ordering Provider Country code	-	This element is not needed
2420E	536	REF		Ordering Provider Secondary ID	s			Required if secondary identification is needed.		This segment is not required unless the information is different with the Claim Level.
			01	Reference ID qualifier	R			Code qualifying the ID. Refer to chart on pages 536-537 of the TIG.	?	If sent, auto plug: "1D"
			02	Ordering Provider Secondary ID	R			Ordering Provider Secondary ID	?	If sent, expect AHCCCS Provider ID and Service Locator Code
2420E	538	PER		Ordering Provider Contact Info	s			Required when services involving an oxygen therapy certificate of medical necessity (CMN) is being billed/reported on this service line.		This segment is not needed.
			01	Contact Function Code	R			Code identifying the major duty of the entity. Use "IC" for Information Contact.	"IC"	Not needed
			02	Order Provider Contact Name	R			Name of ordering provider entity being contacted.	?	Not needed
			03	Communication Number Qualifier	R			Code identifying the type of communication number.	?	Not needed
			04	Communication Number	R			Contact Number	?	Not needed
			05	Communication Number Qualifier	s			Code identifying the type of communication number.	?	Not needed
			06	Communication Number	s			Contact Number	?	Not needed
			07	Communication Number Qualifier	s			Code identifying the type of communication number.	?	Not needed
			08	Communication Number	s			Contact Number	?	Not needed
2420F		**Referring Provider Name**			s				-	Loop 2420F can be sent if different than Claim Level.
2420F	541	NM1		Referring Provider Name	s			Required if this service line involves a referral and the referring provider is different than the rendering provider and if the referring provider differs from that reported at the claim level, loop 2310A.		
			01	Entity ID Code	R			Code identifying an entity or person. Use: "DN" for Referring Provider or "P3" for PCP.	?	If sent, select appropriate HIPAA valid value
			02	Entity Type Qualifier	R			Use "1" for Person.	"1"	If sent, auto plug: "1"
			03	Referring Provider Last Name	R			Referring Provider Name	?	If sent, expect Referring Provider Last Name
			04	Referring Provider First Name	R			Referring Provider Name	?	If sent, expect Referring Provider First Name
			05	Referring Provider Middle Name	s			Referring Provider Name	?	If sent, expect Referring Provider Middle Name
			07	Referring Provider Name Suffix	s			Referring Provider Name	?	This element is not needed
			08	ID Code Qualifier	s			Required if either EIN/SSN or National Provider ID is known.	?	If sent, select appropriate HIPAA valid value
			09	Referring Provider's ID Number	s			Referring Provider's ID Number	?	If sent, expect Referring SSN or EIN

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
2420F	544	PRV		Referring Provider Specialty Info	s					This segment is not needed.
			01	Provider Code	R			Use "RF" for Referring.	"RF"	Not needed
			02	Reference ID qualifier	R			Use "ZZ" to indicate the "Health Care Provider Taonomy" code list of provider specialty codes.	"ZZ"	Not needed
			03	Provider Specialty Code	R				?	Not needed
2420F	547	REF		Referring Provider Secondary ID	s			Required if secondary identification is needed.		This segment is not required unless the information is different with the Claim Level.
			01	Reference ID qualifier	R			Code qualifying the Reference ID. See pages 547-548 of the TIG.	?	If sent, auto plug: "1D"
			02	Referring Provider Secondary ID	R			Referring Provider Secondary ID	?	If sent, expect AHCCCS Provider ID and Service Locator Code
2420G		**Other Payer Prior Authorization or Re**			s				-	Loop 2420G can be sent if different than Claim Level.
2420G	549	NM1		Other Payer Prior Authorization or Referral Name	s			Required when necessary in COB situations to send payer-specific line level referral number or prior authorization number. The payer-specific numbers in this loop belong to the non-destination (COB) payers.		
			01	ID Code Qualifier	R			Use "PR" for Payer.	"PR"	If sent, auto plug: "PR"
			02	Entity Type Qualifier	R			Use "2" for non-person entity.	"2"	If sent, auto plug: "2"
			03	Payer Name	R			Payer Name.	?	If sent, expect Other Payer Organization Name
			08	ID Code Qualifier	R			Code designating the system used for the ID code. Use: "PI" for Payor ID, "XV" for HCFA National PlanID.	?	If sent, select appropriate HIPAA valid value
			09	Other Payer ID Number	R			Other Payer ID Number; must match corresponding Other Payer ID in NM109 in 2330B loops.	?	If sent, expect Other Payer SSN or EIN
2420G	552	REF		Other Payer Prior Authorization or Referral Number	R					This segment is not required. Send if known and applicable
			01	Reference ID qualifier	R			Use: "9F" for Referral Number or "G1" for Prior Auth Number.	?	If sent, select appropriate HIPAA valid value
			02	Other Payer Prior Auth or Referral Number	R			Other Payer Prior Auth or Referral Number	?	If sent, expect valid Referral Number or Prior Auth Number
2430		**Line Adjudication Info**			s				-	
2430	554	SVD		Line Adjudication Info	s			Required if the claim has been previously adjudicated by payer identified in loop 2330B and service line has adjustments applied to it.		
			01	Other Payer Primary ID	R			Other Payer Primary ID; this number should match NM109 in loop 2330B identifying Other Payer.	?	If sent, match NM109 in 2330B (if this is HP ID than SVD02 = HP paid amount)
			02	Service Line Paid Amount	R			Service Line Paid Amount	?	If sent, expect other payor paid Amount (Final Amount)
			03	Procedure ID				Thie element contains the procedure code that was used to pay this service line. It crosswalks from SVC01 in the 835 transmission.	?	
			03-1	Product or Service ID Qualifier	R			**See chart on pages 78-79 of the Addenda.**	?	If sent, select appropriate HIPAA valid value

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			03-2	Procedure Code	R			Procedure Code	?	If sent, expect valid Procedure Code
			03-3	Procedure Modifier 1	s			Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.	?	If sent, expect valid Procedure Modifier 1
			03-4	Procedure Modifier 2	s			Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.	?	If sent, expect valid Procedure Modifier 2
			03-5	Procedure Modifier 3	s			Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.	?	This element is not required. Ignored if sent
			03-6	Procedure Modifier 4	s			Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.	?	This element is not required. Ignored if sent
			03-7	Procedure Code Description	s			A free-form description to clarify the related data elements and their content. Required if SVC01-7 was returned in the 835 transaction.	?	This element is not required. Ignored if sent
			05	Paid units of service - paid service unit count	R			Units of service paid. Crosswalk from SVC05 in 835 or use original billed units.	?	If sent, expect applicable Paid Units of Service
			06	Bundled/Unbundled Line Number	R			Required if payer bundled/unbundled this service line. **Refer to page 80 of Addenda.**	?	If sent, expect applicable Bundled Line Number
2430	558	CAS		Line Adjustment	s					This segment is not required. Send if known and applicable.
			01	Adjustment Group Code	R			Code identifying the general category of payment adjustment. See chart on page 560 of the TIG.	?	If sent, select appropriate HIPAA valid value
			02	Adjustment Reason Code	R			Use the claim adjustment reaso code list in Appendix C of the TIG.	?	If sent, select appropriate HIPAA valid value
			03	Adjustment Amount - Line Level	R			Use this amount for the adjustment amount	?	If sent, expect applicable adjusted amount.
			04	Adjusted Units - Line Level	s			Use this quantity for the units of service being adjusted.	?	If sent, expect applicable adjusted units
			05	Adjustment Reason Code - Line Level	s			Use as needed to show payer adjustment. Use the Claim Adjustment Reason Code list in Appendix C of the TIG.	?	If sent, select appropriate HIPAA valid value
			06	Adjustment Amount - Line Level	s			Use this amount for the adjustment amount	?	If sent, expect applicable adjusted amount.
			07	Adjusted Units - Line Level	s			Use this quantity for the units of service being adjusted.	?	If sent, expect applicable adjusted units
			08	Adjustment Reason Code - Line Level	s			Use as needed to show payer adjustment. Use the Claim Adjustment Reason Code list in Appendix C of the TIG.	?	If sent, select appropriate HIPAA valid value
			09	Adjustment Amount - Line Level	s			Use this amount for the adjustment amount	?	If sent, expect applicable adjusted amount.
			10	Adjusted Units - Line Level	s			Use this quantity for the units of service being adjusted.	?	If sent, expect applicable adjusted units
			11	Adjustment Reason Code - Line Level	s			Use as needed to show payer adjustment. Use the Claim Adjustment Reason Code list in Appendix C of the TIG.	?	If sent, select appropriate HIPAA valid value
			12	Adjustment Amount - Line Level	s			Use this amount for the adjustment amount	?	If sent, expect applicable adjusted amount.
			13	Adjusted Units - Line Level	s			Use this quantity for the units of service being adjusted.	?	If sent, expect applicable adjusted units

Loop	TIG Page	Seg ID	Elem	Name	TIG Usage	Prop Usage	AHCCCS Usage	Notes & Assumptions	HCFA-1500 Location / "Value"	Workgroup Decision
			14	Adjustment Reason Code - Line Level	**s**			Use as needed to show payer adjustment. Use the Claim Adjustment Reason Code list in Appendix C of the TIG.	**?**	**If sent, select appropriate HIPAA valid value**
			15	Adjustment Amount - Line Level	**s**			Use this amount for the adjustment amount	**?**	**If sent, expect applicable adjusted amount.**
			16	Adjusted Units - Line Level	**s**			Use this quantity for the units of service being adjusted.	**?**	**If sent, expect applicable adjusted units**
			17	Adjustment Reason Code - Line Level	**s**			Use as needed to show payer adjustment. Use the Claim Adjustment Reason Code list in Appendix C of the TIG.	**?**	**If sent, select appropriate HIPAA valid value**
			18	Adjustment Amount - Line Level	**s**			Use this amount for the adjustment amount	**?**	**If sent, select appropriate HIPAA valid value**
			19	Adjusted Units - Line Level	**s**			Use this quantity for the units of service being adjusted.	**?**	**If sent, select appropriate HIPAA valid value**
2430	**566**	**DTP**		Line Adjudication Date	**R**					**This element is required if Loop 2430 is used.**
			01	Date Time Qualifier	**R**			Use "573" to denote Date Claim Paid.	**"573"**	**If sent, auto plug: "573"**
			02	Date Time Period Format Qualifier	**R**			Use "D8" to denote date expressed in format of CCYYMMDD.	**"D8"**	**If sent, auto plug: "D8"**
			03	Adjudication or Payment Date	**R**			Adjudication or Payment Date	**?**	**If sent, expect valid adjudication or Payment date**
2440		**Form Identification Code**			**s**				**-**	
	567	**LQ**		Form Identification Code	**s**			Required if the provider is required to routinely include supporting documentaion (a standardized paper form) in electronic format.		**This segment is not required.**
2440			**01**	Form Identification Code	**R**			Code identifying a specific industry code list. See chart on page 568 in the TIG.	**?**	**Not needed**
			02	Form ID	**R**			Form ID	**?**	**Not needed**
2440	**569**	**FRM**		Supporting Documentation	**? R or s ?**			To specify information in response to a codified questionnaire document. **Usage is questionable - is the address for the service facility needed for each service line a claim?**		**This segment is not required.**
			01	Question Number/Letter	**R**					**Not needed**
			02	Question Response	**s**					**Not needed**
			03	Question Response	**s**					**Not needed**
			04	Question Response	**s**					**Not needed**
			05	Question Response	**s**					**Not needed**
-	**572**	**SE**		**Transaction Set Trailer**	**R**					
			01	Transaction Segment Count	**R**			The number of segments included in a transaction set including ST and SE segments.	**calculate**	**Expect Transaction Segment Count in this field. It is generated by most of translator**
			02	Transaction Set Control Number	**R**			The transaction set control numbers in ST02 and SE02 must be identical. The transaction set control number is assigned by the originator and must be unique within a functional group (GS to GE) and interchange (ISA to IEA). This unique number also aids in error resolution research.	**derive**	**Expect the Transaction Set Control in this field - Numbers in ST02 and SE02 must be identical. This element is also generated by most of translator**